

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4219

## CERTIFICATE OF DEATH

Reg. Dist. No. 04212

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>		e. STREET ADDRESS <b>18 Fairmount Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Jane</b> Middle <b>Lyte</b> Last <b>Burrs</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1855</b>
9. AGE (In years last birthday) <b>105</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Lyte</b>		14. MOTHER'S MAIDEN NAME <b>Mary Lyte</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>*****</b>	
17. INFORMANT <b>Maude Hughes, Cambridge, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture right hip</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>1956</b> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 1, 1956</b> to <b>April 6, 1961</b> , that I last saw the deceased alive on <b>April 6, 1961</b> and that death occurred at <b>Md.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>227 Pine St., Cambridge, Md.</b> DATE SIGNED <b>4-10-61</b>			
ACTUAL SIGNATURE <b>J. Edwin Fassett, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/11/1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wagh Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kraus</b>		24a. REC'D BY REGISTRAR DATE <b>APR 20 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

CERTIFICATE OF DEATH

1918

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Vertical text on the right margin, possibly a date or reference number, including the word "GIVEN".

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
04213

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN lb <b>3 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Cambridge Maryland Hosp</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>J</b> Middle <b>Lee</b> Last <b>Burton</b>		4. DATE OF DEATH Month <b>April</b> Day <b>26</b> , Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>December 27, 1905</b>
9. AGE (In years lost birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b> Hours <b>5</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sewing Factory</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Luther Burton</b>		14. MOTHER'S MAIDEN NAME <b>Annie Burton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220 10 6217</b>	
17. INFORMANT <b>Mrs Frances Phillips</b>		Address <b>Cambridge Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis acute</b> DUE TO <b>arterio-sclerotic C.V.D.</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (b) <b>arterio-sclerotic C.V.D.</b> DUE TO (c) <b>arterio-sclerotic C.V.D.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Apr 20, 1961</b> to <b>Apr 26, 1961</b> , that (I) (we) last saw the deceased alive on <b>Apr 26, 1961</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>J. H. Thompson</b>		22b. DATE SIGNED <b>Apr 26, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. H. Thompson</b>		22d. ADDRESS <b>Cambridge, Md.</b>	
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 28, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cambridge Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compe Funeral Service</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 1 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

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may be retained in the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

4221

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04214

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Dor</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Secretary</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Secretary</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Corrie</u> Middle <u>Rebecca</u> Last <u>Colbourne</u>				4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/13/1882</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Sam Moore</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>1</u>			
17. INFORMANT <u>Lloyd Colbourne, Secretary, Md</u> Address <u>Secretary, Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Circumstantial Metastasis</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Epidermoid Carcinoma of Cervix</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>? 2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Arteriosclerotic Heart Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11:55 Jan. 19 41</u> to <u>4/13</u> , 19 <u>61</u> ; that (I) (we) last saw the deceased alive on <u>4/7</u> , 19 <u>61</u> , and that death occurred at <u>9:15</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Louis B. Plummer</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/13/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. H. B. PLUMMER</u>				22d. ADDRESS <u>Preston Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/15/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		23d. LOCATION (City, town, or county) (State) <u>East New Market, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Houghton, Co. N. Market</u>				25a. REC'D BY REGISTRAR <u>APR 19 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4222

04215

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN lb <b>36 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>104 Cedar Street</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> d. STREET ADDRESS <b>104 Cedar Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Helen Alice Cooke</b>		4. DATE OF DEATH <b>April 2, 1961</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 21, 1887</b> yrs. Months Days
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		9b. AGE (In years last birthday) <b>73</b> yrs. Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Cambridge</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James E. Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Emma Figgs</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Kermit Woodward, 306 Peachblossom Ave., Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO (b) <b>Cerebral Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 days 8 months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour s.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/20/61</b> 19 to <b>4/12/61</b> , that (I) (we) last saw the deceased alive on <b>4/1/61</b> 19, end that death occurred at <b>10 A</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Lawrence Maryanov</b> M.D.		22b. DATE SIGNED <b>4/4/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov</b>		22d. ADDRESS <b>136 Race St. Cambridge, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 4, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cambridge, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth A. Thomas</b> ADDRESS <b>Cambridge, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 10 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

4223

04216

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER, CO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER, CO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE, MARYLAND.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BISHOPS HEAD, MARYLAND.</b>			
c. LENGTH OF STAY IN lb <b>3 DAYS</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CAMBRIDGE MARYLAND HOSPITAL</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>1 NONE</b>			
3. NAME OF DECEASED (Type or print) First <b>CLARA</b> Middle <b>LEHMAN</b> Last <b>DAWSON</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>20</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/25/1905</b>	9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>AMBROSE DAWSON</b>				14. MOTHER'S MAIDEN NAME <b>ONEA SHROUT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>LE COMPTE FUNERAL SERVICE, RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mesenteric Thrombosis</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes Mellitus</b> DUE TO (c) <b>Acute Bronchitis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 yrs</b> <b>12 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/18/61</b> to <b>4/20/61</b> , that (I) (we) last saw the deceased alive on <b>4/20</b> 19 <b>61</b> , and that death occurred at <b>2:00</b> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Lawrence Maryanov</b>				22b. DATE <b>4/25/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 22, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DORCHESTER MEMORIAL PARK</b>		23d. LOCATION (City, town, or county) (State) <b>CAMBRIDGE, MARYLAND.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>LE COMPTE FUNERAL SERVICE, CAMBRIDGE, MARYLAND.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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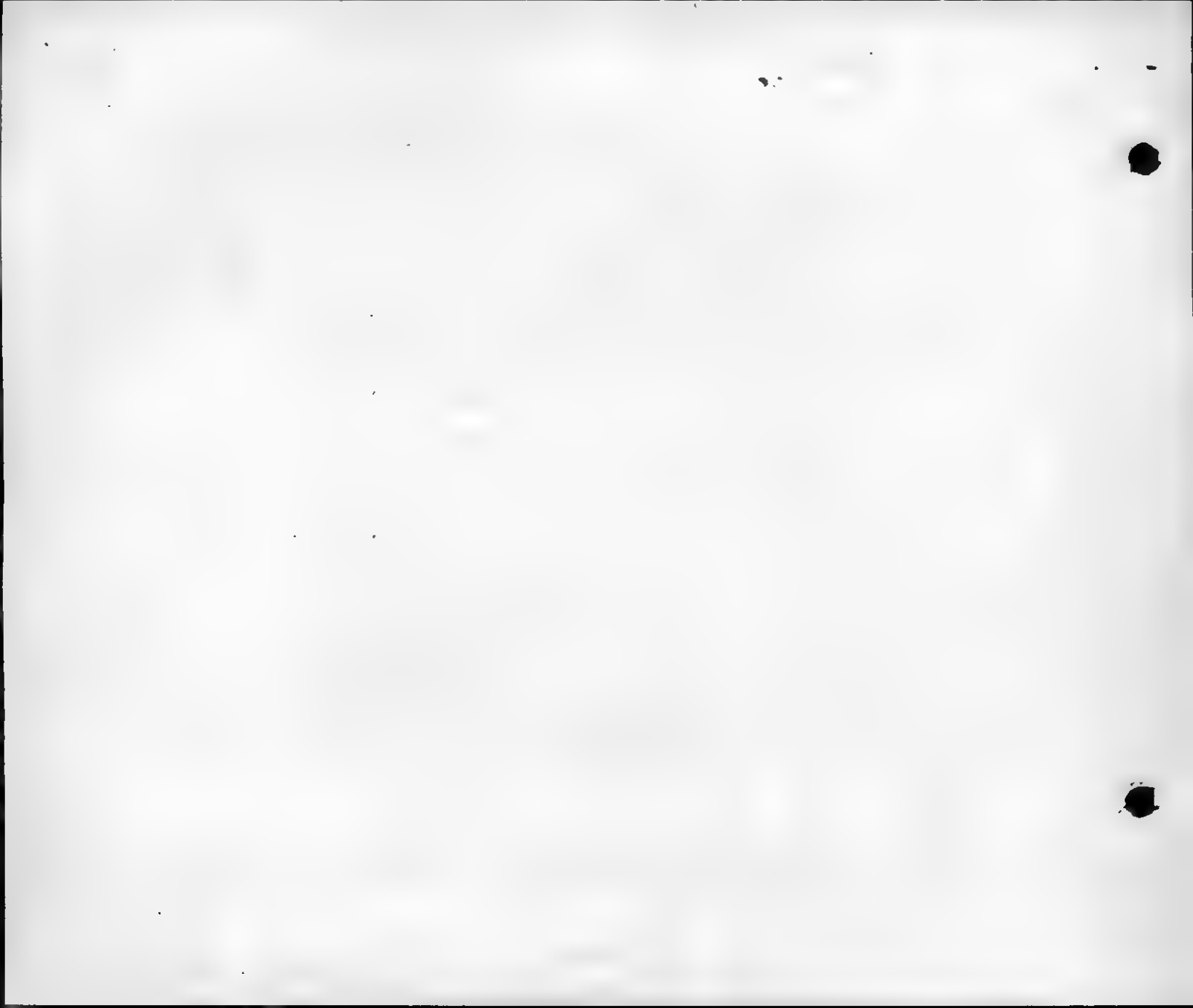
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

4224

04217

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. LENGTH OF STAY IN 1b <b>28 years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>109 Phillips Ave</b>				d. STREET ADDRESS <b>109 Phillips Ave</b>			e. IS RESIDENCE ONLY A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Ethel</b> Middle <b>Gill</b> Last <b>Dayton</b>				4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 28, 1881</b>		9. AGE (In years last birthday) <b>80 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Middletown Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Drummond</b>				14. MOTHER'S MAIDEN NAME <b>Racheal Drummond</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>219 07 8196</b>		17. INFORMANT <b>Mrs Crawford Richardson Cambridge Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF ESOPHAGUS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>undet</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/15</b> 19 <b>60</b> to <b>4/24</b> 19 <b>61</b> , that (I) (we) lost the deceased on <b>4/10</b> 19 <b>61</b> , and that death occurred at <b>4 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Alfred R. Maryanov</b>				M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>4/25/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALFRED R. MARYANOV</b>				22d. ADDRESS <b>136 RACE ST., CAMBRIDGE MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 26, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethesda Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Middletown Delaware</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service Cambridge Maryland</b>				25a. REC'D BY REG-STRAR DATE <b>APR 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Humes</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



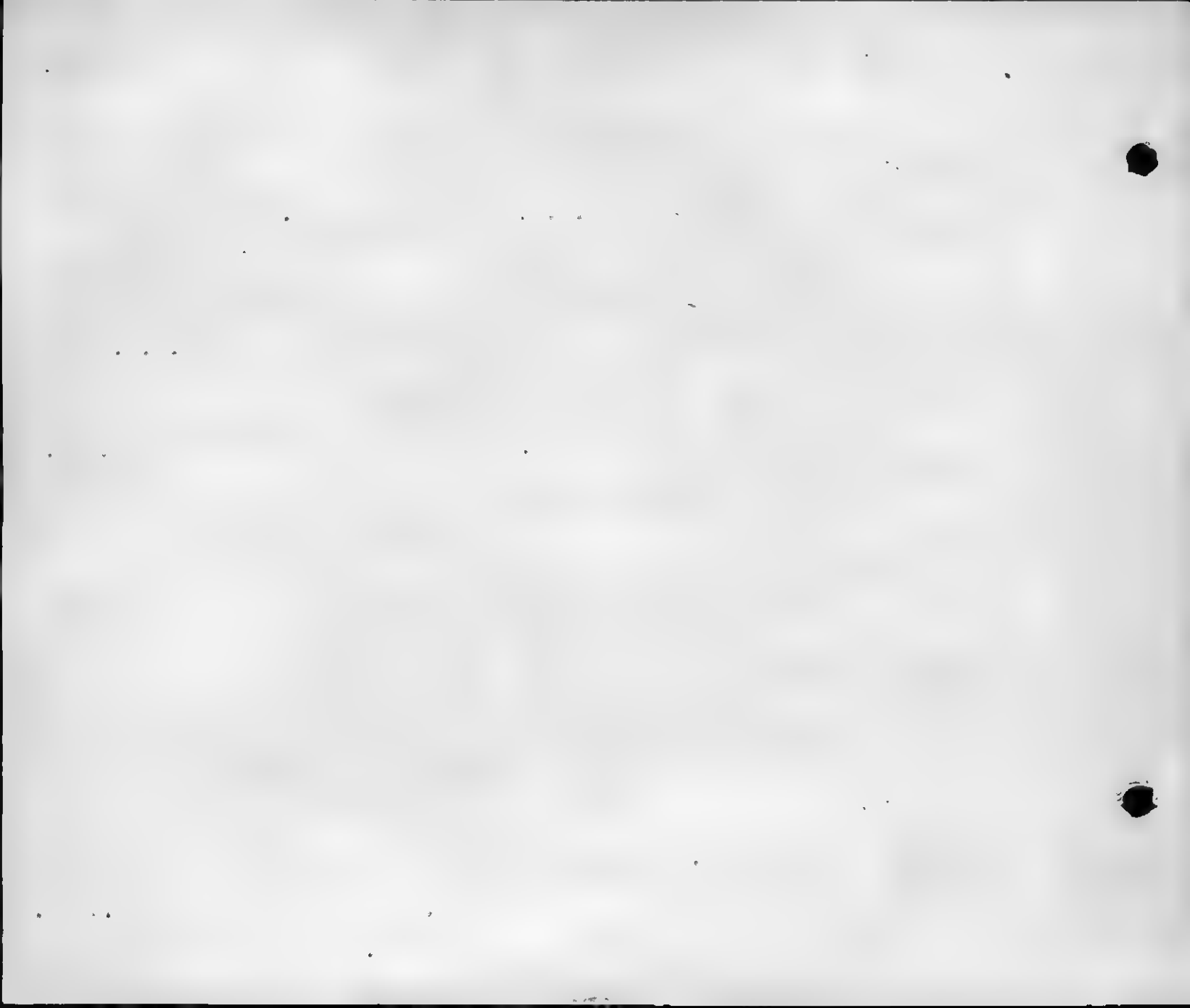
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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
4225 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Item 9 form G-284 4/13/61 3WK 04218									
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN TB <b>Life</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Dorchester</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge Maryland Hospital</b>		e. STREET ADDRESS <b>214 Academy St.</b>		4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1961</b>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Maggie Mae Delaha</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/19/1881</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		9. AGE (in years if UNDER 1 YEAR, last birthday) Months Days Hours Min. <b>79/80</b> yrs.			
13. FATHER'S NAME <b>Frank Todd</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mrs. Howard Wallace</b>		Address <b>Church Creek, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 720-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Instant</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>4/6/61</b> DATE SIGNED Address (Street, city, town, or county) <b>John Mace Jr.</b> EXAMINER'S NAME (Type) ACTUAL SIGNATURE 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>4/8/61</b> 22c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cem.</b> 22d. LOCATION (City, town, or country) <b>East New Market, Dor...Md.</b> 23. FUNERAL DIRECTOR <b>Willoughby Funeral Service East New Market, Md.</b> ADDRESS <b>10/61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>									





## CERTIFICATE OF DEATH

Reg. Dist. No. 04219

4226

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARDELA</u>	
c. LENGTH OF STAY IN 1b <u>8½ MONTHS</u>		d. STREET ADDRESS <u>22X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF <del>DECEASED</del> (Type or print) First Middle Last <u>DORA BELLE DREAPEAU</u>			4. DATE OF DEATH Month Day Year <u>APRIL 16 1961</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 5 1877</u>	9. AGE (in years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WELLER WELCH</u>			
14. MOTHER'S MAIDEN NAME <u>LAVENIA</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO <u>NONE</u>		INFORMANT Address <u>HOSPITAL RECORDS</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF URINARY BLADDER</u> DUE TO (c) <u>MITRAL INSUFFICIENCY</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u> <u>OVER 9 MOS</u> <u>OVER 9 MOS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC BRAIN SYNDROME - SENILE BRAIN DISEASE</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21 I certify that I attended the deceased from JULY 25 1960 to APRIL 16 1961, that I last saw the deceased alive on APRIL 15 1961, and that death occurred at 2:10 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED  
HARRY J. CRAWFORD M.D. EASTERN SHORE STATE HOSP. CAMBRIDGE, MD APRIL 16 1961

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-18-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MARDELA</u>	22d. LOCATION (City, town, or county) (State) <u>MARDELA, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>SMITH FUNERAL HOME, SHARPTOWN, MD</u>		24a. REC'D BY REGISTRAR DATE <u>APR 19 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Finner</u>



## CERTIFICATE OF DEATH

Reg. Dist. No.

04220

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
c. LENGTH OF STAY IN 1b <b>Life</b>		d. STREET ADDRESS <b>12 Dobson Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12 Dobson Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ida Mae Payton Foster</b>		4. DATE OF DEATH Month Day Year <b>April 25 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 21, 1897</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alfred Payton</b>		14. MOTHER'S MAIDEN NAME <b>Mary Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT Address <b>Alice Jackson, Cambridge, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>			
DUE TO (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 1961</b> , to <b>April 25, 1961</b> , that I last saw the deceased alive on <b>April 25, 1961</b> , and that death occurred at <b>1p</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. Edwin Fassett</b>		ADDRESS (Street, city or town, state) <b>227 Pine St., Cambridge, Md.</b> DATE SIGNED <b>4-28-61</b>	
PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/29/1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Michael H. Fassett</b>		24a. REC'D BY REGISTRAR <b>MAY 3 '61</b>	
ADDRESS <b>Cambridge, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. L. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

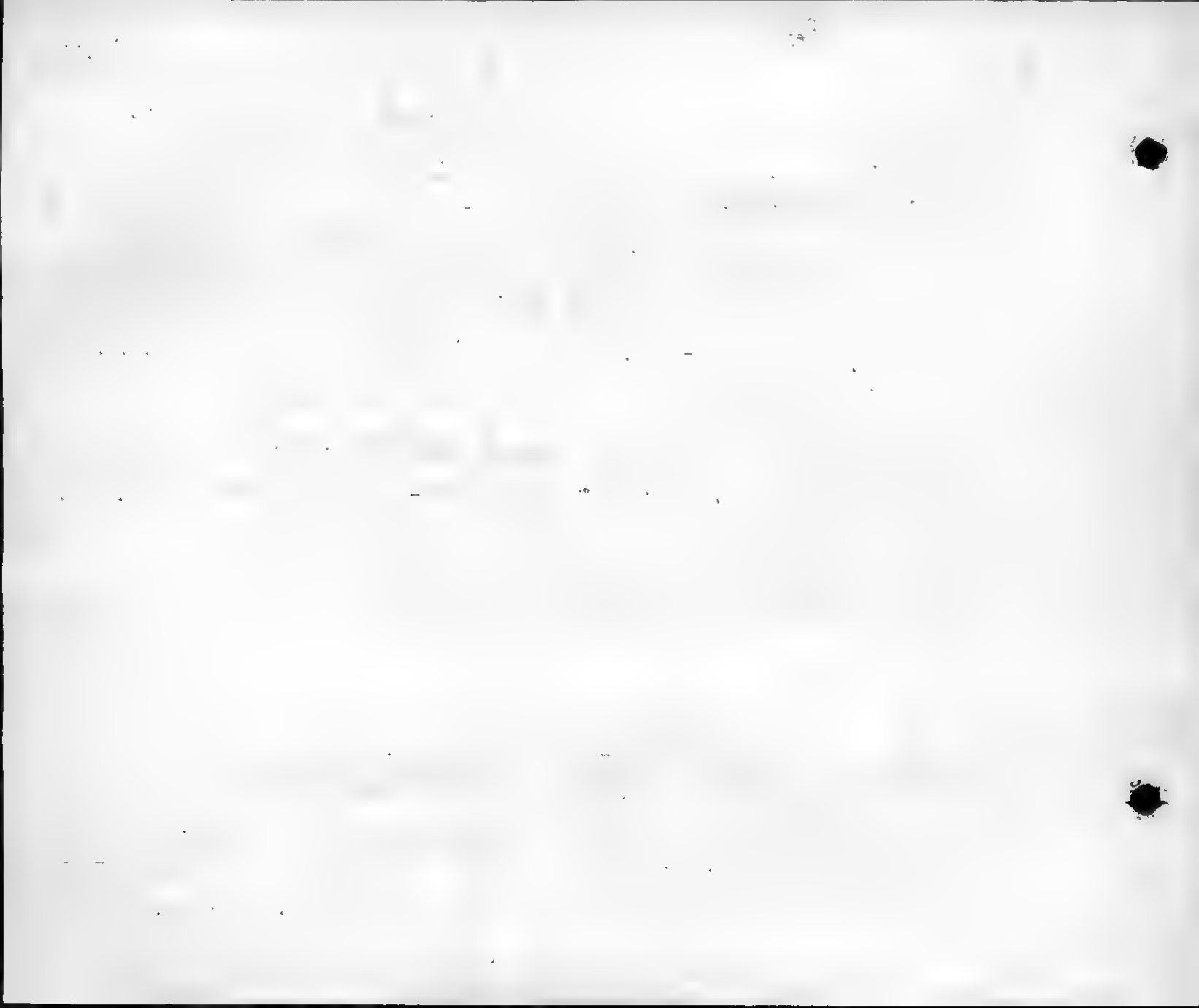


CERTIFICATE OF DEATH

Reg. Dist. No. 04221

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>				d. STREET ADDRESS <b>-</b>			
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Louise</b> Last <b>Hall</b>				4. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 2 1879?</b>	
9. AGE (In years last birthday) <b>82?</b> yrs		IF UNDER 1 YEAR Months <b>82?</b> Days <b>82?</b> Hours <b>82?</b> Min.		IF UNDER 24 HRS Months <b>82?</b> Days <b>82?</b> Hours <b>82?</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>ST MICHAELS MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.?</b>							
13. FATHER'S NAME <b>CHARLES W. WILLEY</b>				14. MOTHER'S MAIDEN NAME <b>SARAH HARRISON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>?</b>			
17. INFORMANT <b>Eastern Shore State Hospital records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis with Cardio-vascular disease</b> DUE TO (b) <b>Sev. yrs.</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sev. yrs.</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-15-</b> <b>1961</b> , to <b>4-18</b> <b>1961</b> , that I last saw the deceased alive on <b>4-18</b> <b>1961</b> , and that death occurred at <b>11:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Eastern Shore State Hospital Cambridge, Maryland</b> DATE SIGNED <b>4-19-61</b>							
ACTUAL SIGNATURE <b>Simon Virkutis</b> M.D. PHYSICIAN'S NAME (Type) <b>Simon Virkutis, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 21, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Springhill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Eastern Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Harrison</b> ADDRESS <b>St Michaels</b>				24a. REC'D BY REGISTRAR <b>APR 24 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harrison</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.





4229  
CERTIFICATE OF DEATH

Reg. Dist. No. 04222

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			
c. LENGTH OF STAY IN 1b <b>Life</b>				d. STREET ADDRESS <b>407 High Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bertie Payton Stafford Hart</b>				4. DATE OF DEATH Month Day Year <b>April 14, 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 20, 1902</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seamstress</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Payton</b>				14. MOTHER'S MAIDEN NAME <b>Hariett Mc Namara</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>214-07-8842</b>		17. INFORMANT Address <b>William Hart, Cambridge, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 10, 1961</b> , to <b>April 14, 1961</b> , that I last saw the deceased alive on <b>April 14, 1961</b> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>227 Pine St., Cambridge 4-15-61</b>							
ACTUAL SIGNATURE <i>[Signature]</i>		M.D. <b>J. Edwin Fassett, M.D.</b>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/16/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>				ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 20 '61</b>	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA AIS (4)  
ISM 9/59

4230

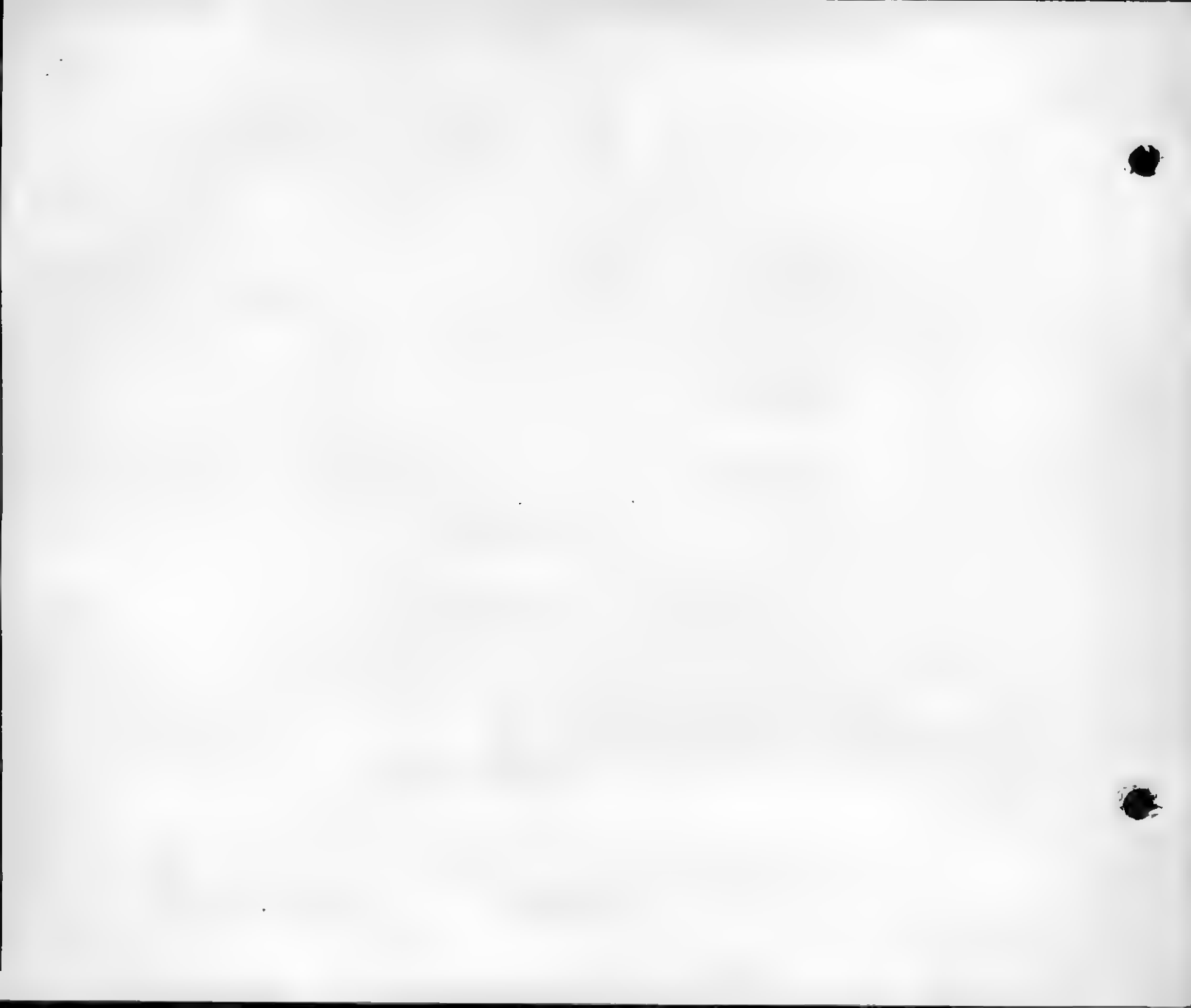
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

04223

1 PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>		c. LENGTH OF STAY IN 1b <b>1 YR. 1 MO.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTERN SHORE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>WALTER EVERETT HASTINGS</b>		4 DATE OF DEATH Month Day Year <b>APRIL 2 1961</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>SEPT. 12, 1875</b>
9 AGE (In years lost birthday) <b>85 yrs</b>		10 IF UNDER 1 YEAR Months Days Hours Min	
11 BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>JOHN W. HASTINGS</b>		14 MOTHER'S MAIDEN NAME <b>THEORA SMOOT</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16 SOCIAL SECURITY NO. <b>221-03-4162A</b>	
17 INFORMANT <b>KATHERINE H. HOPKINS</b>		Address <b>NOTKEY, N.J.</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ARTERIO SCLEROSIS</b> DUE TO (c) <b>UNKNOWN</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 WKS.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>FEB. 25, 1960</b> , to <b>APRIL 2, 1961</b> , that (I) (we) last saw the deceased alive on <b>APRIL 2, 1961</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.			
22a SIGNATURE <b>George H. Longley</b>		22b DATE SIGNED <b>APRIL 2, 1961</b>	
22c PHYSICIAN'S NAME (Type) <b>GEORGE H. LONGLEY</b>		22d ADDRESS <b>RFD 2, CAMBRIDGE, MD.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>April 5, 1961</b>	23c NAME OF CEMETERY OR CREMATORY <b>Galestown Cemetery</b>	23d LOCATION (City, town, or county) (State) <b>Galestown, Maryland</b>
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J. J. Frounpton &amp; Son, Federalburg, Maryland</b>		25a REC'D BY REGISTRAR DATE <b>APR 10 '61</b>	25b REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

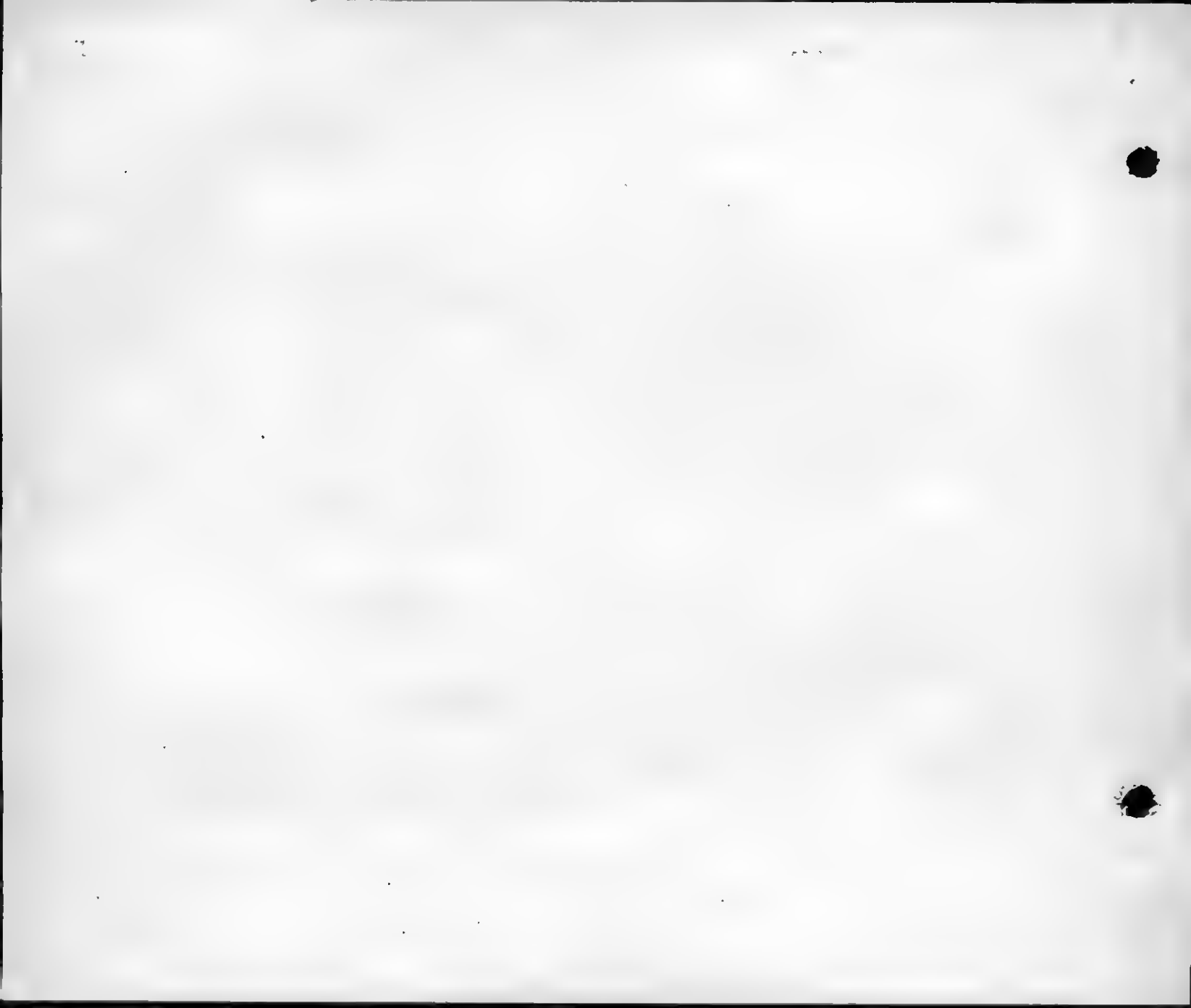


4231

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04224

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Madison, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Shore State Hospital</u>		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Estelle</u> Last <u>Hazzington</u>		DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/30/1872</u>
9. AGE (in years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Schepler</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Fooo</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Hospital Records</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis with Cardiovascular Disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>10/25</u> to <u>4/15</u> 19 <u>61</u> ; that (I) (we) last saw the deceased alive on <u>April 15</u> 19 <u>61</u> , and that death occurred at <u>4:15</u> P.M. from the causes and on the date stated above			
22a. SIGNATURE <u>Simon Virkutis</u>		22b. DATE SIGNED <u>4/15/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Simon Virkutis</u>		22d. ADDRESS <u>Eastern Shore St. Hospital, Cambridge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/17/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GETHSAMANE CHURCH</u>		23d. LOCATION (City, town, or county) <u>MADISON MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		25. REGISTRAR'S SIGNATURE <u>Arthur S. Fenn</u>	





4232

4225

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>3 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge-Maryland Hospital</b>		e. STREET ADDRESS <b>Thompstontown</b>	
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>E.</b> Last <b>Henry</b>		4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 7, 1897</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months <b>63</b> Days <b>63</b> Hours <b>63</b> Min.	11. IF UNDER 24 HRS Months <b>63</b> Days <b>63</b> Hours <b>63</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Hurlock, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Eugene Coleman</b>		14. MOTHER'S MAIDEN NAME <b>Susie A. Harris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>161-14-0331</b>	
17. INFORMANT <b>Mrs. Bertha Dockins, East New Market, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Arteriosclerotic Heart Disease</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 1, 1961</b> to <b>April 29, 1961</b> that (I) (we) last saw the deceased alive on <b>April 29, 1961</b> and that death occurred at <b>12:50 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>J. Edwin Fassett, M.D.</b>		22b. DATE SIGNED <b>5-2-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>		22d. ADDRESS <b>227 Pine St., Cambridge, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 3, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Thompstontown Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Near East New Market, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 8 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If you please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

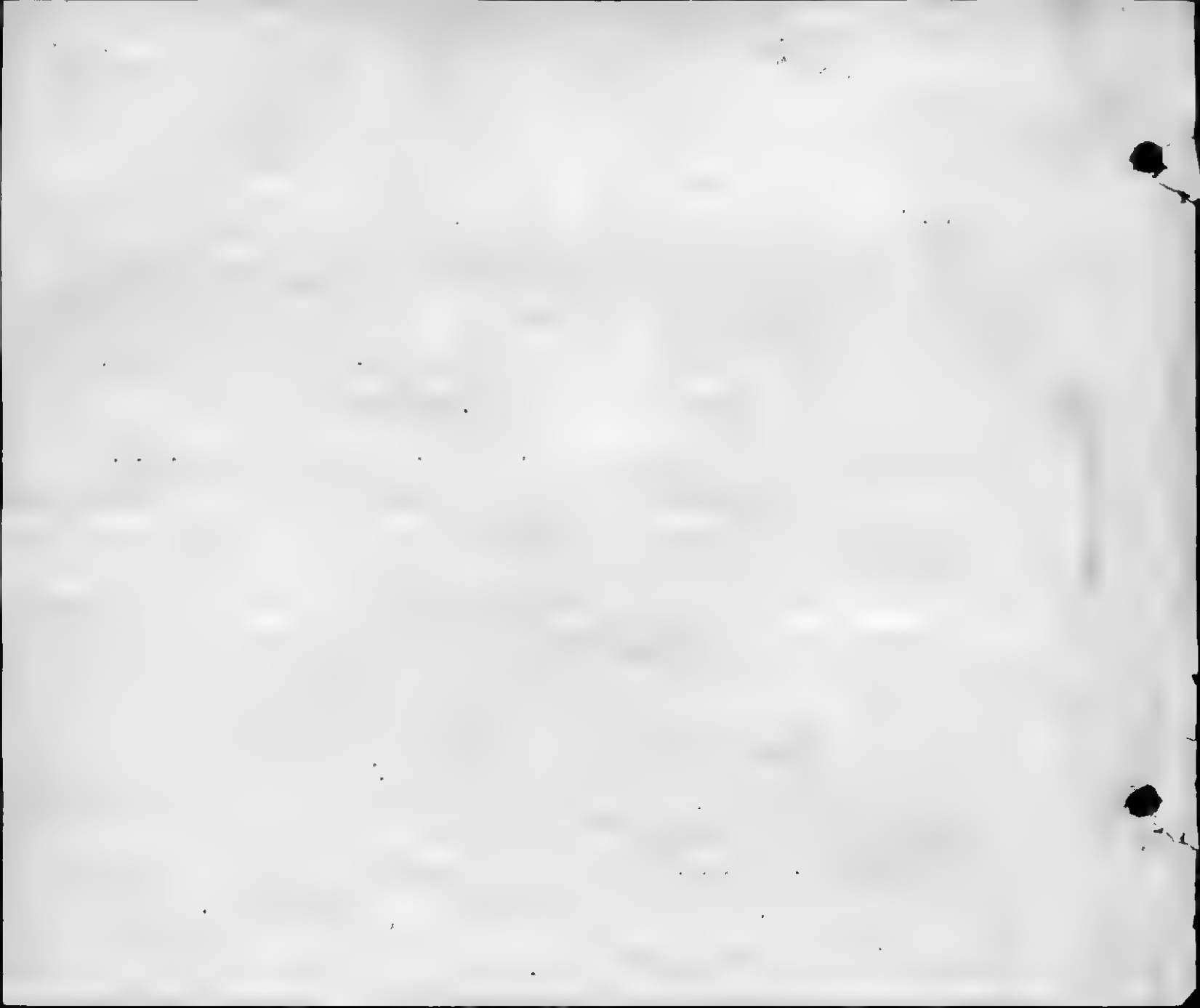
<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICS, RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN TB <u>10 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.D. 2</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> d. STREET ADDRESS <u>R.D. 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Lewis Henry Hickman</u>						<b>4. DATE OF DEATH</b> <u>April 4, 1961</u> 19 <u>19</u>					
<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>February 23, 1918</u>						<b>9. AGE</b> (In years last birthday) <u>43 yrs.</u> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Radio Operator Sheriff's Office</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Paston, Md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>					
<b>13. FATHER'S NAME</b> <u>Frank L. Hickman</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>G. Myrtle Hamner</u>						<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <b>16. SOCIAL SECURITY NO.</b> <u>221-10-2853</u> <b>17. INFORMANT</b> <u>Mrs. T. L. Hickman, Cambridge, Md., R.D. 2</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Coronary sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>2 months +</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): <u>Patient had Myocardial infarction 2-28-61 and 3-6-61</u>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. _____				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____			
<b>20f. (City or town)</b> _____				<b>20g. (County)</b> _____				<b>20h. (State)</b> _____			
<b>21. I certify that (1) (this hospital) attended the deceased from <u>2-28-61</u> to <u>4-4-61</u>, 19<u>61</u>, that (1) <del>(was)</del> last saw the deceased alive on <u>4-1</u> 19<u>61</u>, and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Eldridge H. Wolff</u> M.D.						<b>22b. DATE SIGNED</b> <u>4-6-61</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Eldridge H. Wolff, M.D.</u>						<b>22d. ADDRESS</b> <u>15 Locust St., Cambridge, Maryland</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>April 7, 1961</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Windy Hill Cemetery</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Windy Hill, Md.</u>				<b>23e. (State)</b> _____				<b>23f. (Country)</b> _____			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Kenneth R. Thomas</u>						<b>24b. ADDRESS</b> <u>Cambridge, Md.</u>					
<b>25a. REC'D BY REGISTRAR</b> DATE <u>APR 10 '61</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Evans</u>							

04226

M

I

MEDICAL CERTIFICATION



## CERTIFICATE OF DEATH

Reg. Dist. No.

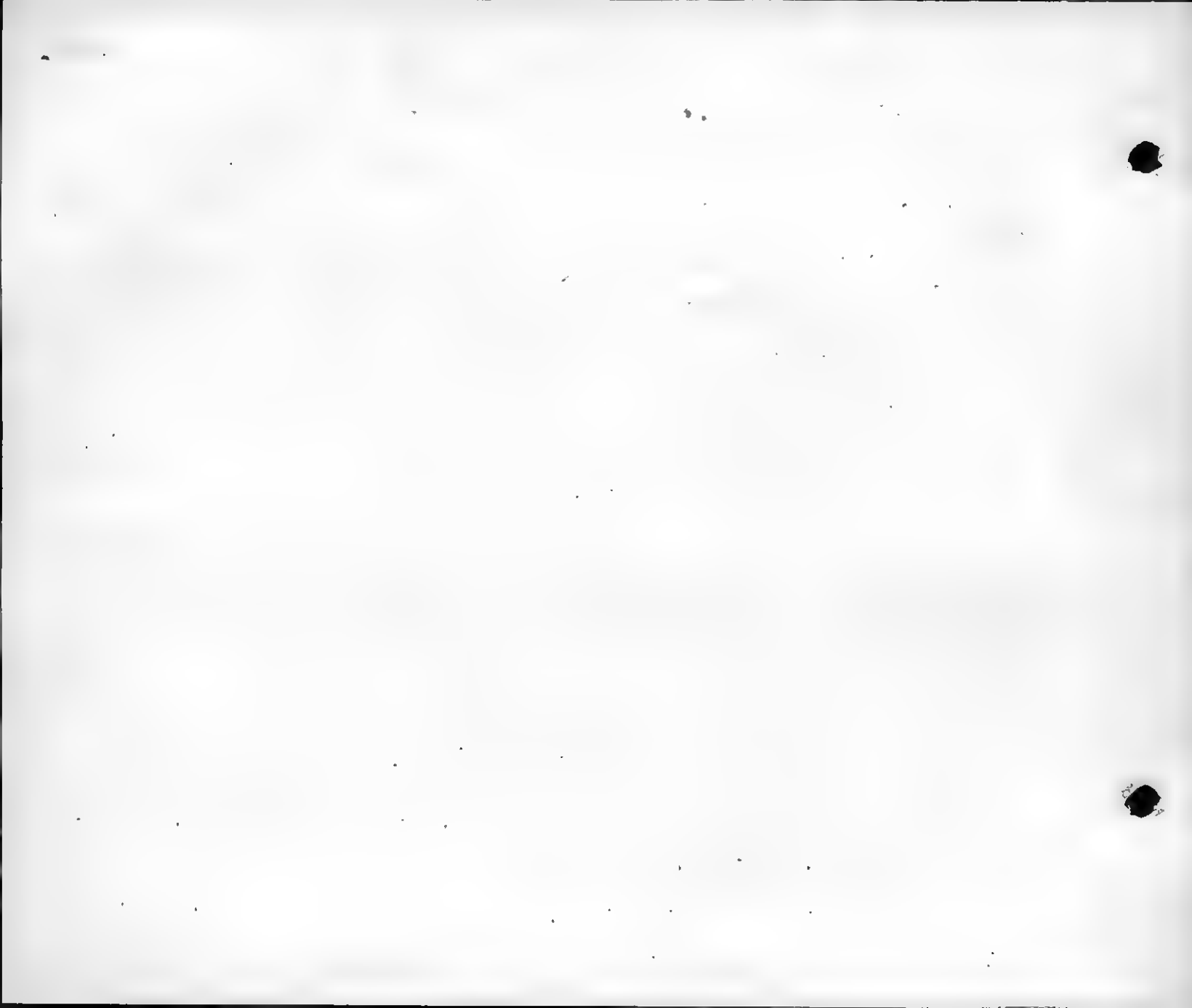
04227

4234

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Res dence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Ken-</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Still Pond, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		d. STREET ADDRESS <b>— 14X-1</b>	
3. NAME OF DECEASED (Type or print) First <b>Kate</b> Middle <b>Laman</b> Last <b>Howard</b>		4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-11-76</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL OFFICE</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Howard</b>		14. MOTHER'S MAIDEN NAME <b>Mary Clark</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>218-30-0942A</b>	
17. INFORMANT <b>Hospital records</b>		Address <b>Cambridge Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>General Arteriosclerosis</b> <b>450.0</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>unk</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 13, 1958</b> to <b>April 7, 1961</b> , that I last saw the deceased alive on <b>April 7, 1961</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>F.B.S. Hospital, Cambridge, Md. 4-7-61</b>			
ACTUAL SIGNATURE <b>Thomas J. Dredge</b>		PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-10-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>STILL POND CEMT</b>		22d. LOCATION (City town, or county) (State) <b>STILL POND, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Victor N. Kennedy</b>		24a. REC'D BY REGISTRAR <b>DATE 4-10-61</b>	
ADDRESS <b>STILL POND, MD</b>		24b. REGISTRAR'S SIGNATURE <b>Wm J. Thomas</b>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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M  
4235  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04228

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OXFORD</b>			
c. LENGTH OF STAY IN 1b <b>3 MONTHS</b>				d. STREET ADDRESS <b>MORRIS 20X-1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTERN SHORE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>HARRY F HUBBARD</b>				4. DATE OF DEATH Month Day Year <b>APRIL 15 1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 2 1888</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATERMAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>FISHING</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>LEWIS HUBBARD</b>				14. MOTHER'S MAIDEN NAME <b>EMMA GORKRAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WWI</b>				16. SOCIAL SECURITY NO. <b>219 142750</b>		17. INFORMANT Address <b>HOSPITAL RECORDS.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF KIDNEY</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC BRAIN SYNDROME - CEREBRAL HEMORRHAGE</b>							INTERVAL BETWEEN ONSET AND DEATH <b>OVER 5 MOS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21 I certify that (1) (this hospital) attended the deceased from <b>JAN. 1961</b> to <b>APRIL 15, 1961</b> , that (1) (we) last saw the deceased alive on <b>APRIL 15, 1961</b> , and that death occurred at <b>11 PM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>Harry J. Crawford</b> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> <b>APRIL 16, 1961</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>HARRY J. CRAWFORD</b>				22d. ADDRESS <b>EASTERN SHORE STATE HOSP. CAMBRIDGE MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>April 18, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oxford</b>		23d. LOCATION (City, town, or county) (State) <b>Oxford MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. ...</b>				25a. REC'D BY REGISTRAR DATE <b>APR 18 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	



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4236

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04229

1 PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>	
c. LENGTH OF STAY IN 1b <b>13 days</b>		d. STREET ADDRESS <b>Morris Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fisher Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Sarah E. Hubbard</b>		4. DATE OF DEATH Month Day Year <b>April 22 1961</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 10, 1881</b>
9 AGE (In years last birthday) <b>79 yrs</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11 BIRTHPLACE (State or foreign country) <b>Caroline Co., Maryland</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Andrew</b>	
14 MOTHER'S MAIDEN NAME <b>Kate Jester</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Roland Johnson, Federalsburg, Md., R.F.D.</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary occlusion</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last (b) <b>Chronic Corruptive heart failure</b> DUE TO (c) <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>5 yrs</b> <b>?</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Federalsburg, Maryland, RFD</b>	
21 I certify that (I) (this hospital) attended the deceased from <b>April 10, 1961</b> to <b>April 22, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 21, 1961</b> , and that death occurred at <b>10:30 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>DR. H. B. PLUMMER</b>		22b. DATE SIGNED <b>4/25/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. H. B. PLUMMER</b>		22d. ADDRESS <b>Preston Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 25, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland, RFD</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalsburg, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>APR 28 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Harris</b>			

(M)

(I)



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

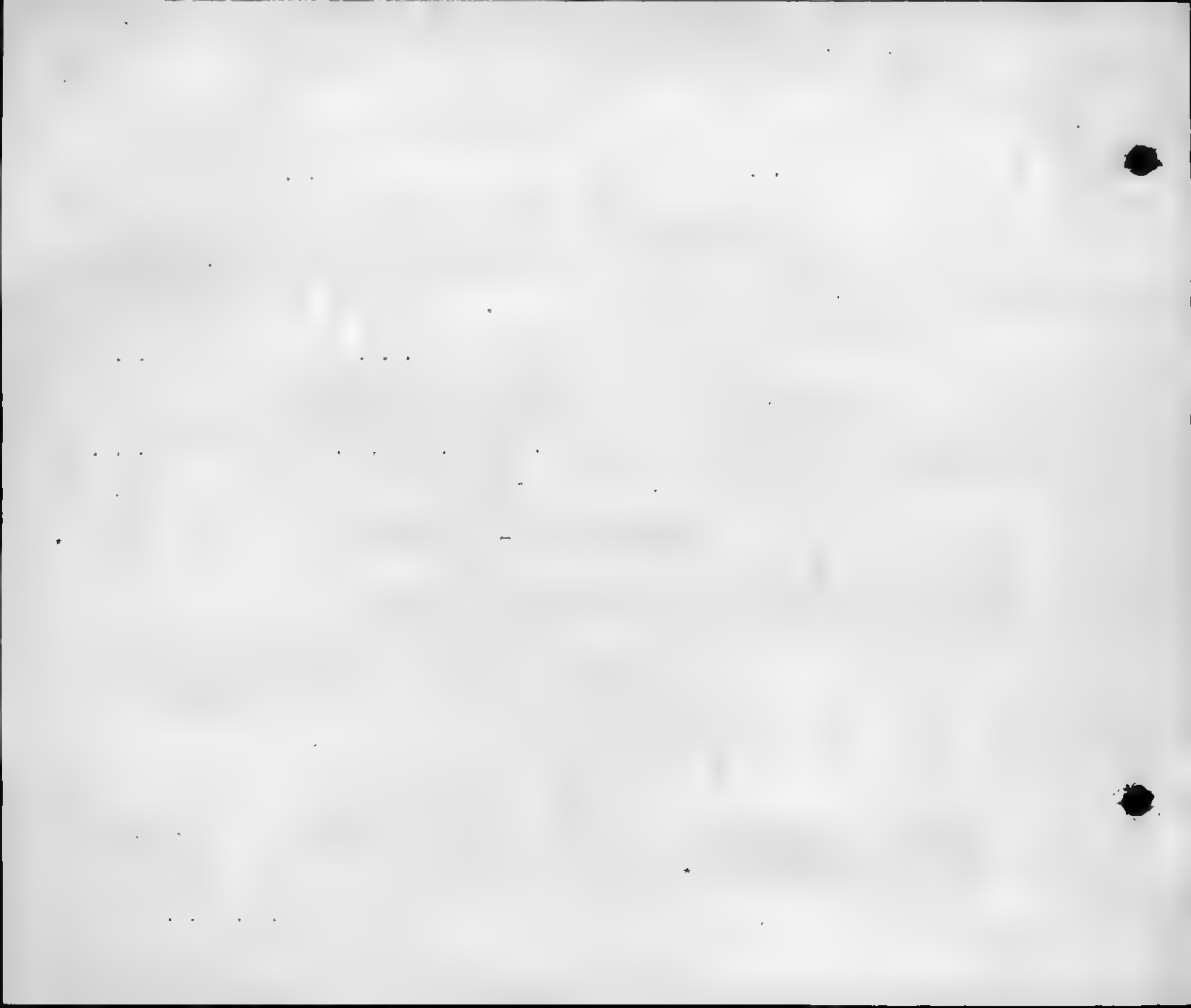
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

4237

04230

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <b>Cambridge, P.D. 1</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge, P.D. 1</b>			
c. LENGTH OF STAY IN TB <b>32 Years</b>				d. STREET ADDRESS <b>Rural</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rural</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Lyda Johnson Jones</b>		First Middle Last		4. DATE OF DEATH <b>April 20, 1961</b>		Day Month Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 23, 1889</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		11. BIRTHPLACE (State or foreign country) <b>Cambridge, R.D. 3</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Phillip M. Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Palmer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. 17. INFORMANT <b>Mr. James R. Jones, Jr., Cambridge, Md., R.D. 3</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive C-V Disease</b> (a), stating the underlying cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) <b>Instant</b> <b>10 yrs.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Mace Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>April 22, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Jones Family Cemetery</b>	
23. FUNERAL DIRECTOR <b>Kenneth R. Thomas</b>				22d. LOCATION (City, town, or country) <b>Cambridge, Md., R.D.</b>		(State)	
24b. REC'D BY REGISTRAR <b>MAY 1 '61</b>				24c. REGISTRAR'S SIGNATURE <b>Clifford L. Thomas</b>			

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

Reg. Dist. No. 04231

4238

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge-Rural</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Naamon</b> Middle <b>Kane</b> Last <b>Kane</b>		4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 8, 1906</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR: Months <b>54</b> Days <b>3</b> Hours <b>19</b> Min <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles C. Kane</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Clash</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>220-12-1716</b>	
17. INFORMANT <b>Cinderella Kane, RFD 2, Cambridge, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> DUE TO <b>Arteriosclerosis Aortae</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>10</b> Day <b>10</b> Year <b>1958</b> Hour <b>4:30</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/10/58</b> to <b>4/3/61</b> , that I last saw the deceased alive on <b>4/3/61</b> , and that death occurred at <b>5:30 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. H. Hanks, MD</b>		DATE SIGNED <b>4/4/61</b>	
PHYSICIAN'S NAME (Type) <b>W. H. Hanks, MD</b>		ADDRESS (Street, city or town, state) <b>104 Locust St Cambridge, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/9/1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hughes Mission Ceme.</b>	22d. LOCATION (City, town, or county) (State) <b>Dorchester County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard M. S. Class</b>		24a. REC'D BY REGISTRAR <b>APR 10 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





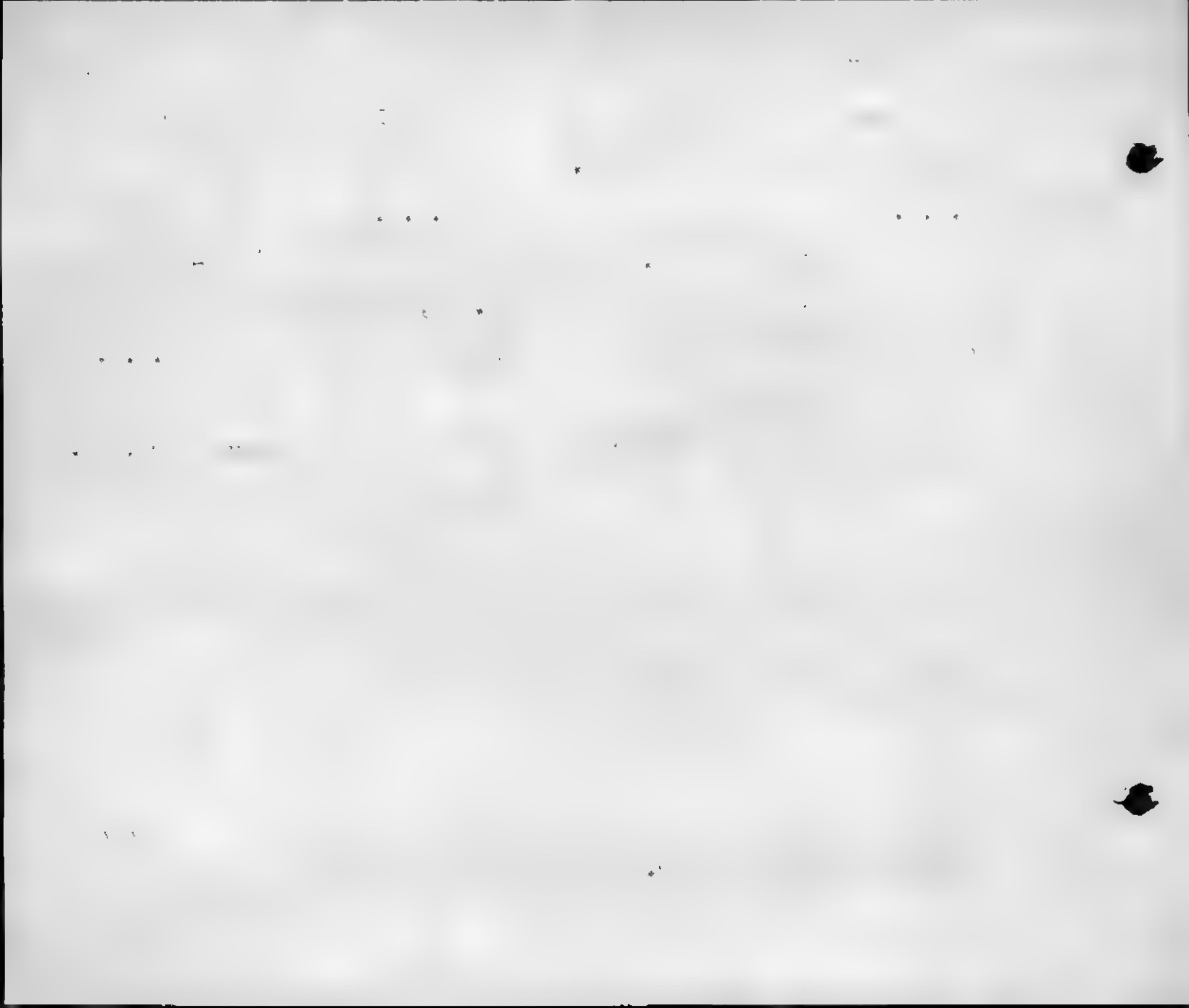
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

<div> <div>1</div> <div>4239</div> <div>04232</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div>									
<b>1. PLACE OF DEATH</b> COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b> c. LENGTH OF STAY IN 1b <b>8 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.F.D. 2</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b> d. STREET ADDRESS <b>R.F.D. 2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <b>John Henry Kessler</b> <b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>Sept. 18, 1882</b> <b>9. AGE</b> (In years last birthday) <b>78</b> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>chef in hotels</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Food</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Switzerland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>					<b>4. DATE OF DEATH</b> Month <b>4</b> Day <b>4</b> Year <b>19 61</b> <b>13. FATHER'S NAME</b> <b>Unknown</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>Unknown</b> <b>16. SOCIAL SECURITY NO.</b> <b>078-09-3430</b> <b>17. INFORMANT</b> <b>Roland Wright</b> Address <b>Federalsburg, Md.</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State) <b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <b>4/5/61</b>									
<b>ACTUAL SIGNATURE</b> <b>EXAMINER'S NAME (Type)</b> <b>John Mace Jr.</b> <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>22b. DATE THEREOF</b> <b>April 8, 1961</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Hill Crest Cemetery</b> <b>22d. LOCATION (City, town, or country)</b> (State) <b>Federalsburg, Maryland</b>									
<b>23. FUNERAL DIRECTOR</b> <b>J.J. Frampton and Son, Federalsburg, Maryland</b> <b>24a. REC'D BY REGISTRAR</b> <b>DATE APR 10 '61</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hanna</b>									



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04233**

**4240**

FOR STATE  
HEALTH DEPT.

**M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER, CO.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE, MARYLAND.</b> c. LENGTH OF STAY IN TB <b>3 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER, CO.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X CAMBRIDGE, MARYLAND, R.F.D. # 2.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CAMBRIDGE MARYLAND HOSPITAL</b>		d. STREET ADDRESS <b>NONE</b>	
3. NAME OF DECEASED (Type or print) First <b>MARAGARET</b> Middle <b>BRANNOCK</b> Last <b>MILLS</b>		4. DATE OF DEATH Month <b>4</b> Day <b>13</b> Year <b>19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/18/1912</b>
9. AGE (In years last birthday) <b>48</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEVIN W. BRANNOCK</b>		14. MOTHER'S MAIDEN NAME <b>ALVERTA GORE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>YES</b>	
17. INFORMANT <b>MR. CARL MILLS R.F.D. # 2, CAMBRIDGE, MARYLAND.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DORIDEN POISONING</b> <b>970.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Took about 25 Gr. Doriden</b>	
20c. TIME OF INJURY Month Day Year <b>4-9- 19 61</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Cambridge Dor. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		DATE SIGNED <b>4/19/61</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>APRIL 15, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GREENLAWN CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>CAMBRIDGE, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>LE COMPTE FUNERAL SERVICE, CAMBRIDGE, MARYLAND.</b>		24. REC'D BY REGISTRAR <b>APR 21 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	



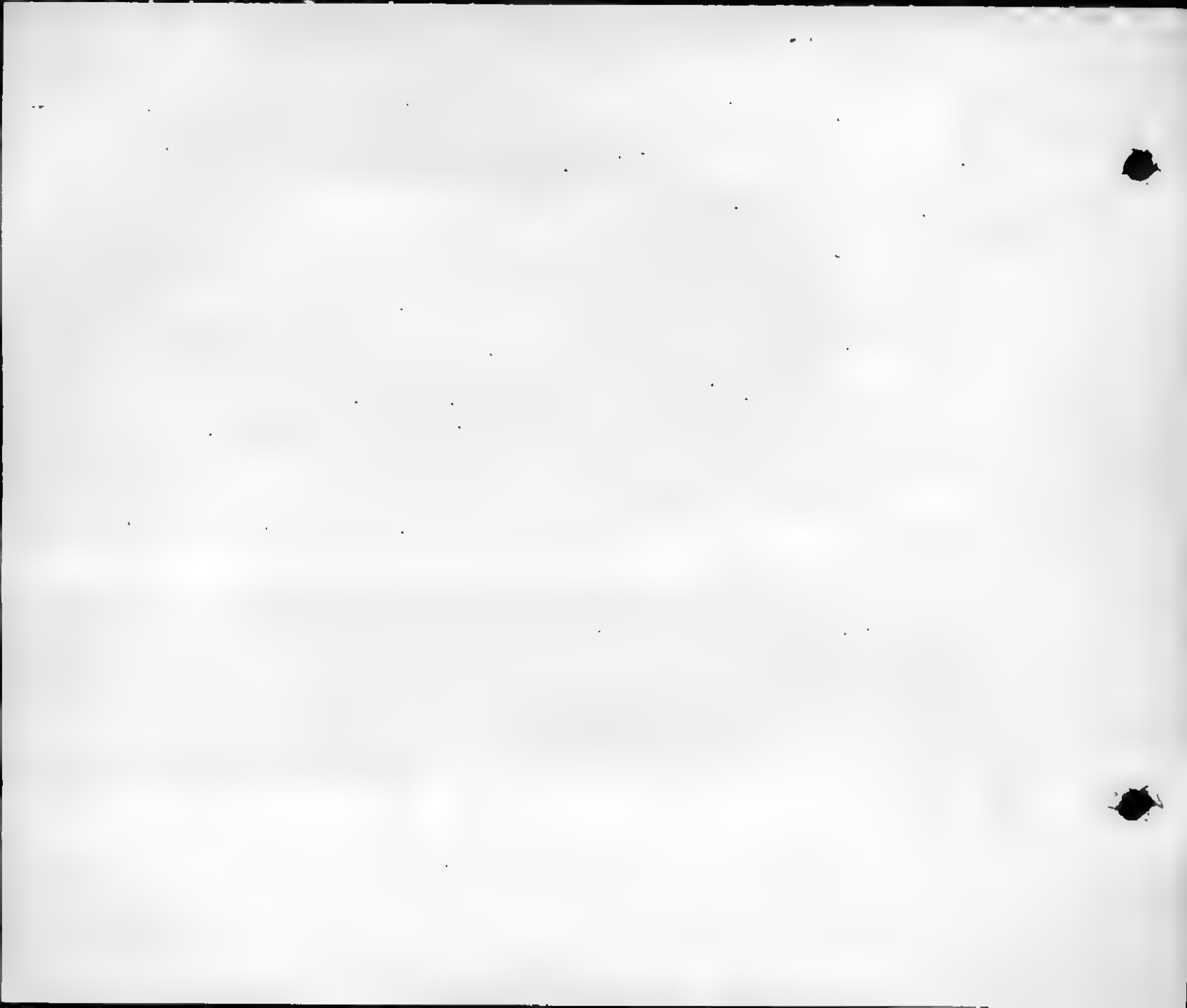
TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

4241  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04234

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <i>MD</i> b. COUNTY <i>Dor</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN 1b <i>10 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cambridge Maryland</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Catherine Clifton Moore</i>		4. DATE OF DEATH Month Day Year <i>4 / 10 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/4/1894</i>
9. AGE (In years last birthday) <i>64</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Surman Clifton</i>		14. MOTHER'S MAIDEN NAME <i>Emma Percy</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>42-111111</i>	
17. INFORMANT <i>Mrs. Walter Collins Secretary Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Coronary artery disease</i>		(b) <i>18 days</i>	
(c) <i>Toxic Myocarditis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cholemia (Severe) Common Duct Obstruction</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>3/20 1961</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>3/20</i> 1961 to <i>4/10</i> 1961, that (I) (we) last saw the deceased alive on <i>4/10</i> 1961, and that death occurred at <i>3 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>W. H. Hanks</i>		22b. DATE SIGNED <i>4/10/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. H. HANKS</i>		22d. ADDRESS <i>CAMBRIDGE MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/12/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>East New Market</i>		23d. LOCATION (City, town, or county) (State) <i>East New Market, MD</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John S. Hallyday</i>		25a. REC'D BY REGISTRAR <i>APR 17 '61</i>	
ADDRESS <i>East New Market</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanks</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1c, Film G286 5/1/61 iwk

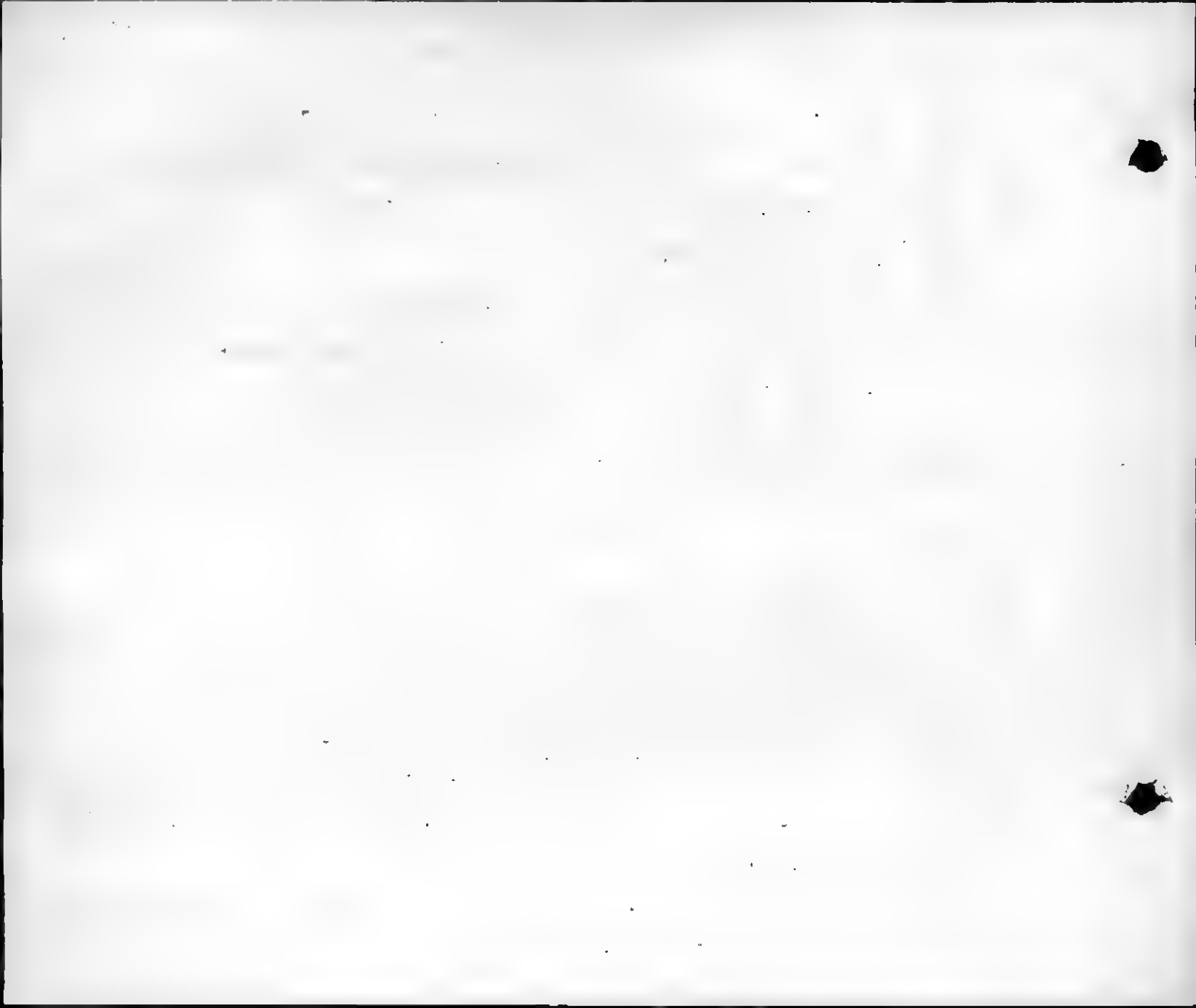
## CERTIFICATE OF DEATH

Reg. Dist. No. 04235

4242

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b> c. LENGTH OF STAY N 1b <b>4 months &amp; 19 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>Woodstock Station</del> <b>Rhodesdale</b> d. STREET ADDRESS <b>Brookview</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Leona</b> Middle <b>Albertine</b> Last <b>Murphy</b>		4. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 3, 1871</b>
9. AGE (In years last birthday) <b>89 90</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>George W Paine</b>	
14. MOTHER'S MAIDEN NAME <b>Albertine Mills</b>		15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> 4-20 DUE TO (b) <b>Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH <b>Link</b>
21. I certify that I attended the deceased from <b>Nov 29, 1960</b> to <b>Apr 18, 1961</b> , that I last saw the deceased alive on <b>Apr 17, 1961</b> , and that death occurred on <b>2:35 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Thomas J. Dredge M.D. E.S.S. Hospital, Cambridge, Md. 4-18-61</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 21, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Brookview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Brookview, Dorchester Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 25 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>			

TO HOSPITAL OR TO FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HICOMICO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
c. LENGTH OF STAY IN 1b <b>From 9.7.60</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) <b>PARSONS HOME FOR AGED</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Eastern Shore St. Hospital</b>		e. STREET ADDRESS <b>Naylor Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Kilmon</b> Last <b>Parker</b>		4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>1961</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1880</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>80</b> Days <b>22</b> Hours <b>15</b> Min <b>15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Tiberius Kilmon</b>		14. MOTHER'S MAIDEN NAME <b>Alice Christine Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-9256</b>	
17. INFORMANT <b>Hospital Records</b>		Address <b>—</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis with C. V. D.</b> DUE TO <b>carcinoma - nose and forehead</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> DUE TO <b>—</b> (c) <b>—</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. <b>19</b> p. m. <b>7:45</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9.7.1960</b> to <b>4.22.1961</b> , that (I) (we) last saw the deceased alive on <b>4/22.1961</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above			
22a. SIGNATURE <b>Simon Vilkuotis</b>		22b. DATE SIGNED <b>April 22, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Simon Vilkuotis</b>		22d. ADDRESS <b>East Shore State Hosp. Cambridge</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/25/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>PARSONS CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>SALISBURY, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co Salisbury, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 26 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>		25c. REGISTRAR'S NAME <b>Norman H. Baker</b>	

MEDICAL CERTIFICATION



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

04237

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>2hrs. 22mins</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vienna</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Perkins</u>			4. DATE OF DEATH Month Day Year <u>April 19 1961</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1961</u>		9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>2 22</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Asie Bell Perkins</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Blake</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Elizabeth Perkins Vienna, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>176X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 19, 1961</u> , to <u>April 19, 1961</u> , that I last saw the deceased alive on <u>April 19, 1961</u> , and that death occurred at <u>11:20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Albert E. Bunker</u>		M.D. <u>200 Maryland Ave</u>		ADDRESS (Street, city or town, state) <u>Cambridge, Maryland</u>		DATE SIGNED <u>4/19/61</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Albert E. Bunker</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>4-19-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Md. Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE <u>APR 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ISM 9/59

1

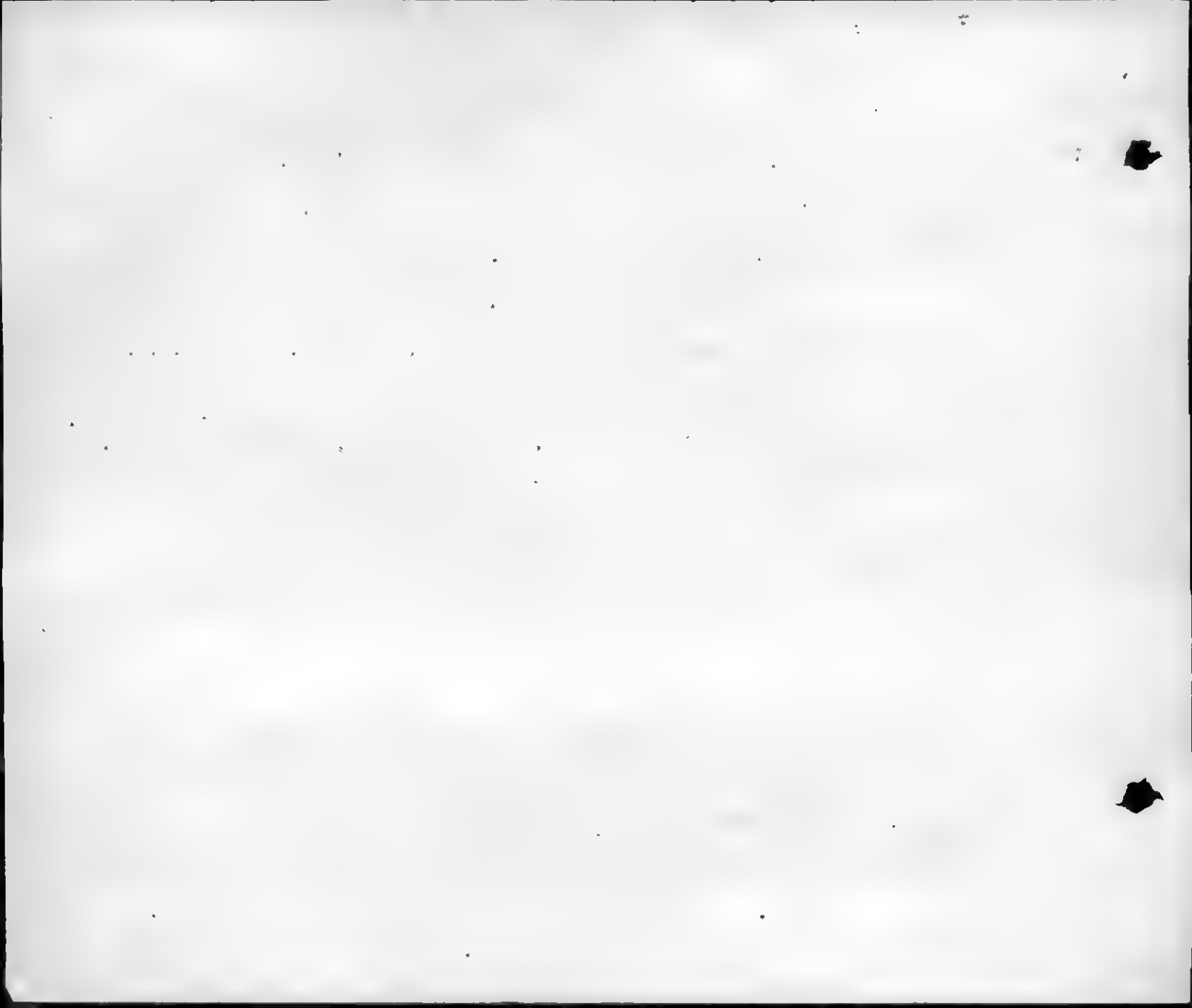
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

4245

04238

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER, CO.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER, CO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE, MARYLAND.</b>		c. LENGTH OF STAY IN 1b <b>1 WEEK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CAMBRIDGE MARYLAND HOSPITAL</b>		d. STREET ADDRESS <b>WASHINGTON, STREET.</b>	
3. NAME OF DECEASED (Type or print) First <b>SIDNEY</b> Middle <b>PHILLIPS</b> Last <b>PHILLIPS</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 27 1880</b>
9. AGE (In years last birthday) yrs. <b>80</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SAW MILL OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SAW MILL OPERATOR</b>	
11. BIRTHPLACE (State or foreign country) <b>ANDREWS, MARYLAND.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>NO</b>	
17. INFORMANT <b>CAMBRIDGE, MARYLAND.</b>		18. MR. EDWARD PHILLIPS, WASHINGTON, STREET.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> 72001 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BRONCHIAL ASTHMA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/10/49</b> to <b>5 APRIL 1961</b> , that (I) (we) last saw the deceased alive on <b>4 APRIL 1961</b> , and that death occurred on <b>5 APRIL 1961</b> at <b>1445 A.M.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>W. E. GUNBY JR.</b>		22b. DATE SIGNED <b>7 APRIL 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. E. GUNBY JR.</b>		22d. ADDRESS <b>CAMBRIDGE Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4/9/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>DORCHESTER MEMORIAL PARK</b>	23d. LOCATION (City, town, or county) (State) <b>CAMBRIDGE, MARYLAND.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>LE COMPTE FUNERAL SERVICE, CAMBRIDGE, MARYLAND.</b>		25a. REC'D BY REGISTRAR <b>DATE APR 10 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Carlton L. Kneass</b>

M



1  
FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4246

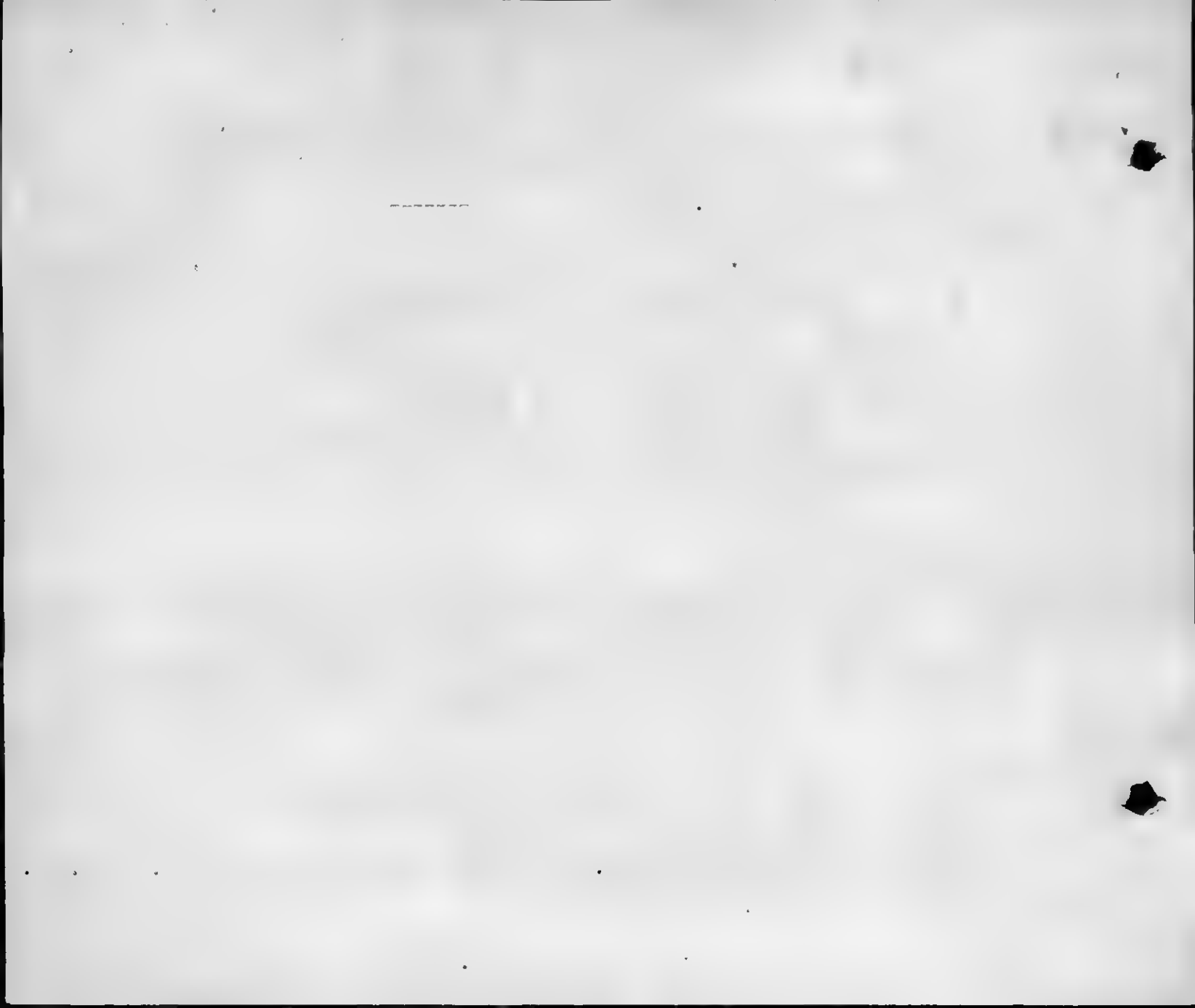
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04239

1. PLACE OF DEATH County <b>Dorchester</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	c. LENGTH OF STAY in lb <b>DOA</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crapo</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge Maryland Hosp. DOA</b>		d. STREET ADDRESS <b>DOA</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>John R.</b> Middle <b>Pyle</b> Last <b>Pyle</b>		4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 7, 1913</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>	9. AGE (In years last birthday) <b>47</b> yrs.
11. 8TH PLACE (State or foreign country) <b>Somerset Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Daniel Pyle</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Pyle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs John Pyle Crapo Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY EMBOLUS</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 HRS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <b>Alfred R. Maryanov</b> M.D. <b>4/27/61</b> DATE SIGNED EXAMINER'S NAME (Type) <b>Alfred R. Maryanov, M.D.</b> Address (Street, city, town, or county) <b>136 Race St., Camb., Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 29, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Gardner of Faith</b>	22d. LOCAT ON (City, town, or county) (State) <b>Baltimore Maryland</b>
23. FUNERAL DIRECTOR <b>Le Compte Funeral Service Cambridge Maryland.</b>		24. REC'D BY REGISTRAR   24b. REGISTRAR'S SIGNATURE <b>MAY 1 '61</b> <b>Arthur S. Kross</b>	

VS. A15ME  
SM 9/60

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

4247

04240

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER, CO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER, CO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE, MARYLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE, MARYLAND.</b>			
c. LENGTH OF STAY IN 1b <b>10 YEARS</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CAMBRIDGE MARYLAND HOSPITAL</b>				d. STREET ADDRESS <b>527 OAKLEY, STREET.</b>			
3. NAME OF DECEASED (Type or print) First <b>EARLE</b> Middle <b>S.</b> Last <b>RICHARDSON</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>22</b> Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 23 1909</b>	
9. AGE (In years last birthday) <b>51</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SPECIAL INVESTIGATOR</b>		11. BIRTHPLACE (State or foreign country) <b>ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES E. RICHARDSON</b>				14. MOTHER'S MAIDEN NAME <b>ANGELA STAHL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>				16. SOCIAL SECURITY NO <b>YES</b>		17. INFORMANT <b>MRS EARLE RICHARDSON, 527 OAKLEY, ST.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis</b> DUE TO (b) <b>Leakage from duodenal stump</b> DUE TO (c) <b>Post-op gastric resection</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b> <b>4/14/61</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Apr 4, 1961</b> , to <b>Apr. 20, 1961</b> , that (I) (we) last saw the deceased alive on <b>Apr 20, 1961</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Lewis M. Burdette</b> M.D.				22b. ADDRESS <b>1 Locust St. Cambridge, Md.</b>			
22c. PHYSICIAN'S NAME (Type) <b>Lewis M. Burdette</b>				22d. ADDRESS <b>1 Locust St. Cambridge, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 22, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service, Cambridge, Maryland.</b>				25a. REC'D BY REGISTRAR <b>APR 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. K...</b>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM  
SM 7/59

FOR STATE  
HEALTH DEPT

M

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4243

04241

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN It <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>300 West End Ave.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> d. STREET ADDRESS <b>300 West End Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph Robbins</b> First Middle Last		4. DATE OF DEATH <b>April 5 19 61</b> Month Day Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/12/1897</b> Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oil distributor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>American Oil Co. Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William J. Robbins</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Cook</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Mrs. Joseph Robbins</b>		Address <b>Cambridge, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>4/6/61</b> DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/7/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Park</b>		22d. LOCATION (City, town, or country) (State) <b>Cambridge, Dor. Md.</b>	
23. FUNERAL DIRECTOR <b>Le Compte Funeral Service, Cambridge, Md.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>APR 10 '61</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

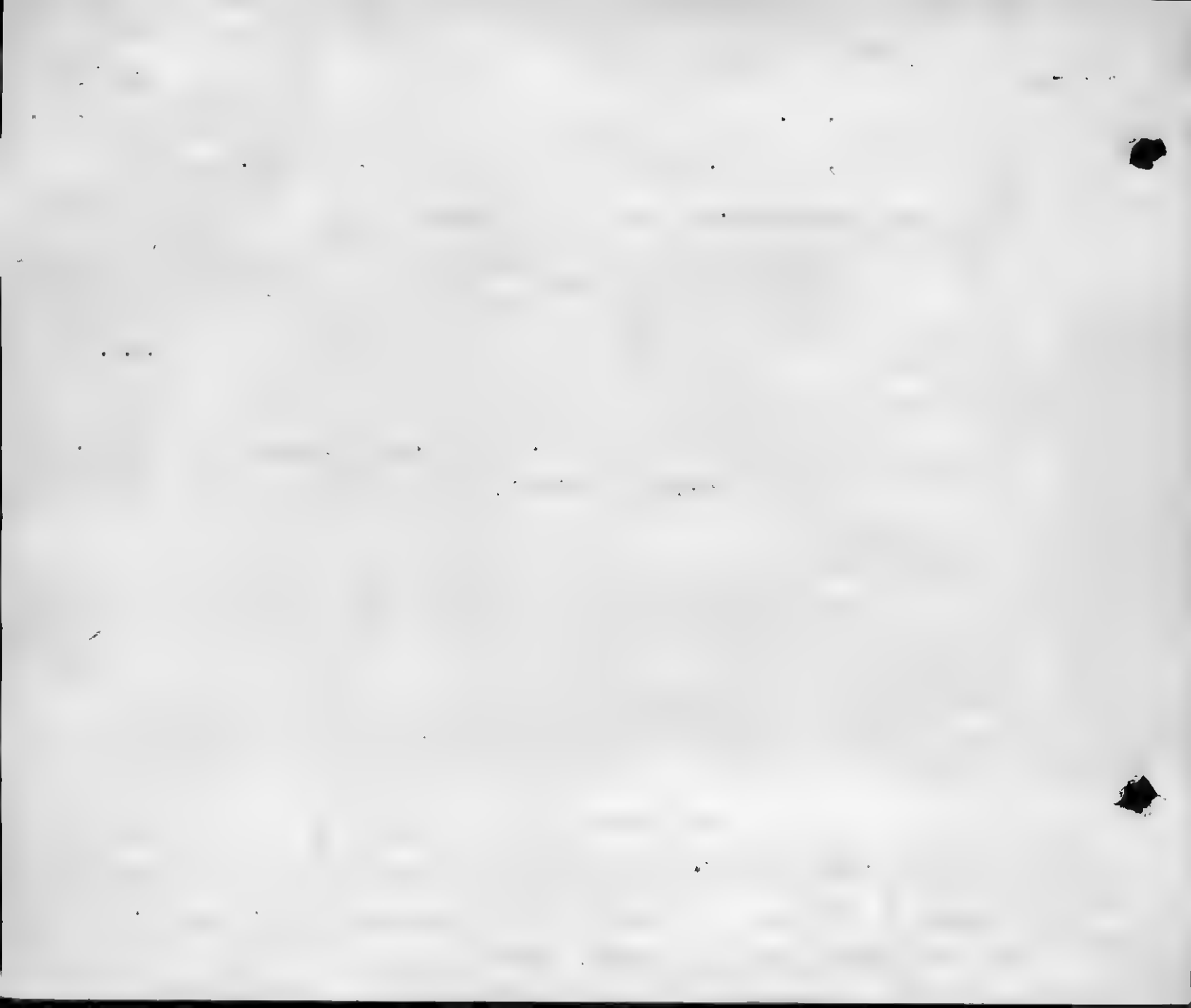
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER, CO.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER, CO.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TAYLORS ISLAND, MARYLAND.</b> d. STREET ADDRESS <b>NONE</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TAYLORS ISLAND, MARYLAND.</b> c. LENGTH OF STAY in lb <b>LIFE</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>TAYLORS ISLAND, MARYLAND.</b>		3. NAME OF DECEASED (Type or print) <b>LEVI RUARK</b>		4. DATE OF DEATH Month <b>4</b> Day <b>4</b> Year <b>19 1961</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>UNKNOWN</b>		9. AGE (In years last birthday) <b>ABOUT 70 yrs.</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>EDWARD RUARK</b>		14. MOTHER'S MAIDEN NAME <b>MARY RUARK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>MR. GROVER C. HOOVER, CAMBRIDGE, MARYLAND.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO (e), stating the underlying cause last. (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		DATE SIGNED <b>4/6/61</b>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/6/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>DORCHESTER MEMORIAL PARK</b>	
22d. LOCATION (City, town, or country) <b>CAMBRIDGE, MARYLAND.</b>		22e. REC'D BY REGISTRAR <b>APR 10 '61</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
23. FUNERAL DIRECTOR <b>LE COMPTE FUNERAL SERVICE, CAMBRIDGE, MARYLAND</b>					



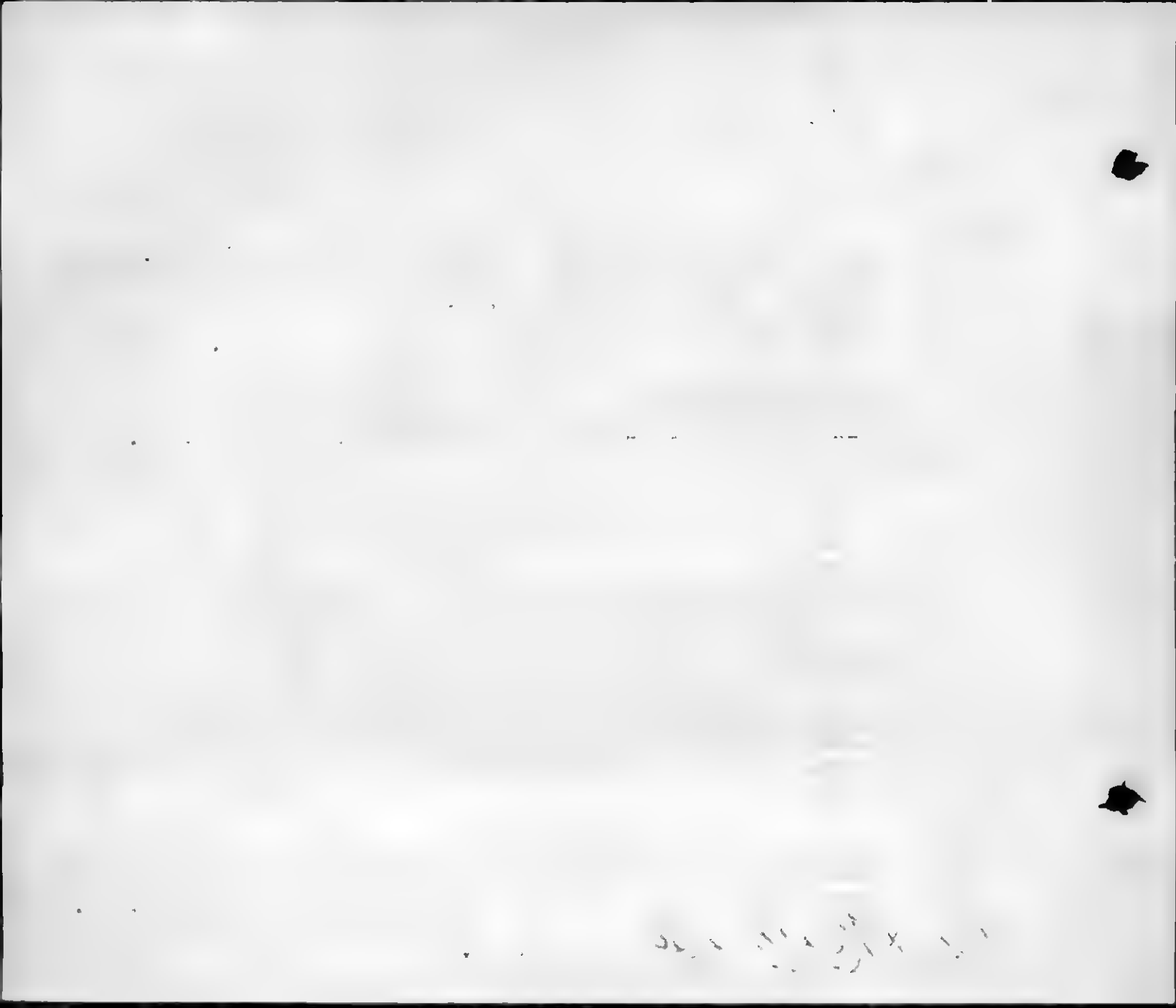
## CERTIFICATE OF DEATH

Reg. Dist. No. 04243

1 PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>108 Pine Street</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> d. STREET ADDRESS <b>108 Pine Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mariah Elizabeth Holland Sampson</b> First Middle Last		4. DATE OF DEATH Month Day Year <b>April 2, 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 7, 1923</b>
9. AGE (In years last birthday) <b>38</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Claibourne Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Alice Holland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-03-4895</b>	
17. INFORMANT <b>Herman Sampson, Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Circumstances with pleurisy pneumonia</b> <b>145X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension, malignant</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emigration</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>6 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> to <b>April, 1961</b> that I last saw the deceased alive on <b>April 1, 1961</b> , and that death occurred at <b>Md.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cambridge, Md.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>James W. Thompson</b> M.D.		PHYSICIAN'S NAME (Type) <b>James W. Thompson</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/7/1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Old Field Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Dorchester County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kraus</b>		24a. REC'D BY REGISTRAR DATE <b>APR 10 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04244

4251

Even. lc. Film G206 5/1/61 iwk

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.PLACE OF DEATH  
a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL  
and give nearest town)

Cambridge

c. LENGTH OF STAY IN 1b

33 yrs 8 mos 8 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Perryville

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

E.S. State Hospital

d. STREET ADDRESS

e. IS RESIDENCE  
ON A FARM?  
YES ☐ NO ☒3. NAME OF  
DECEASED  
(Type or print)

Roy K. Sentman

4. DATE  
OF  
DEATHMonth Day Year  
April 23 1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

11/4/93

9. AGE (In years  
last birthday)

67 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Any labor

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

A.J. Sentman

14. MOTHER'S MAIDEN NAME

~~Hattie Gillespie~~ Addie Gillespie15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Records E.S.S. Hospital Cambridge, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Coronary occlusion

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN  
ONSET AND DEATH  
Instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY  
PERFORMED?  
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS  
PRIMARY ☐ or CONTRIBUTING ☐  
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY  
Month, Day, Year  
Hour a. m.  
p. m.

19

20d. INJURY OCCURRED  
While  
at work ☐ Not while  
at work ☐20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☐, and in my  
opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐ACTUAL  
SIGNATURE

John Mace Jr.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

4/23/61

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

22b. DATE THEREOF

4-26-61

22c. NAME OF CEMETERY OR CREMATORY

Hopewell Ceme

22d. LOCATION (City, town, or county)

Port Deposit, Md. R.O.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

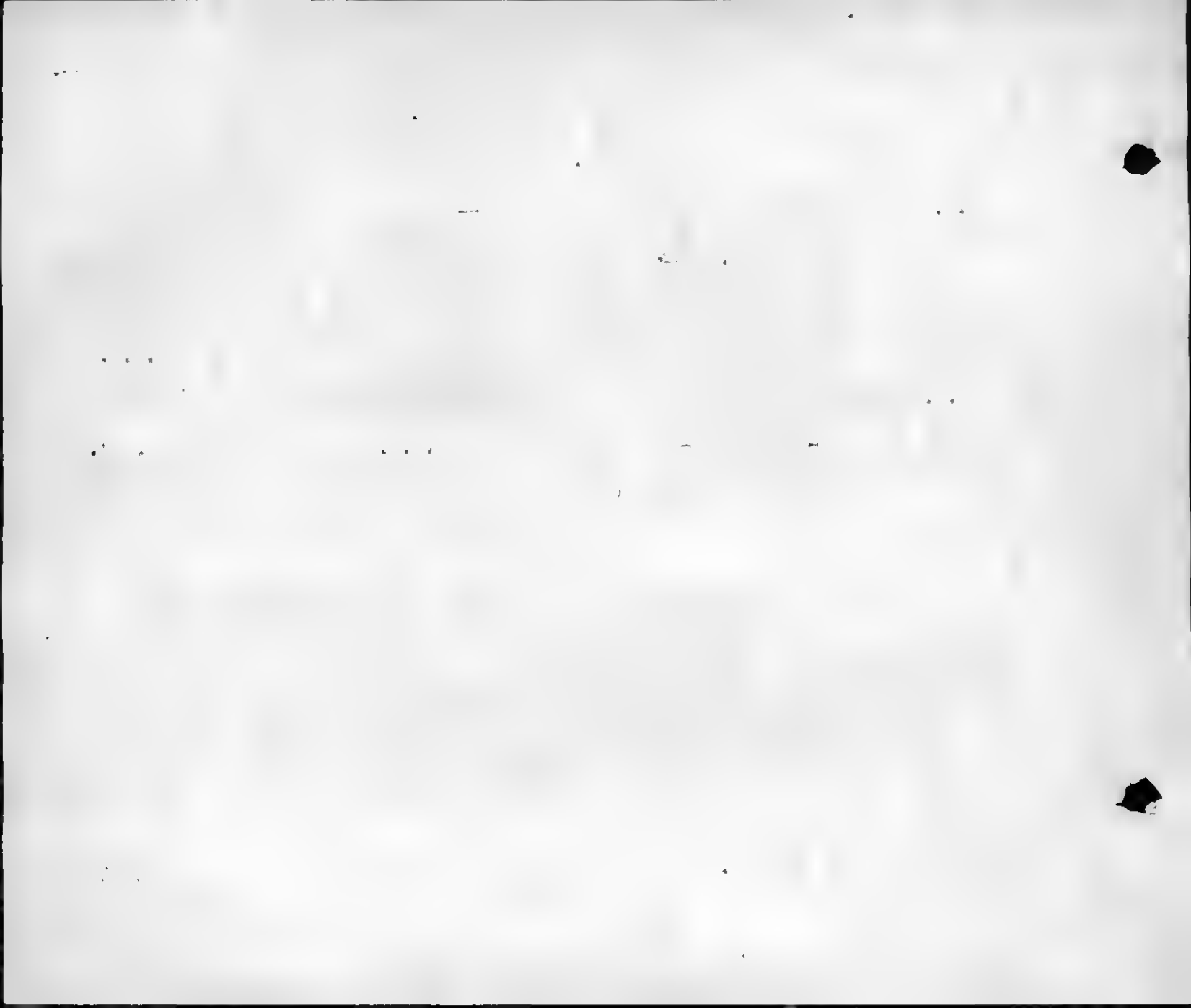
24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

See A. Patterson &amp; Son Perryville, Md.

DATE

April 25 '61



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1c Film G-85 4/19/61 mh

## CERTIFICATE OF DEATH

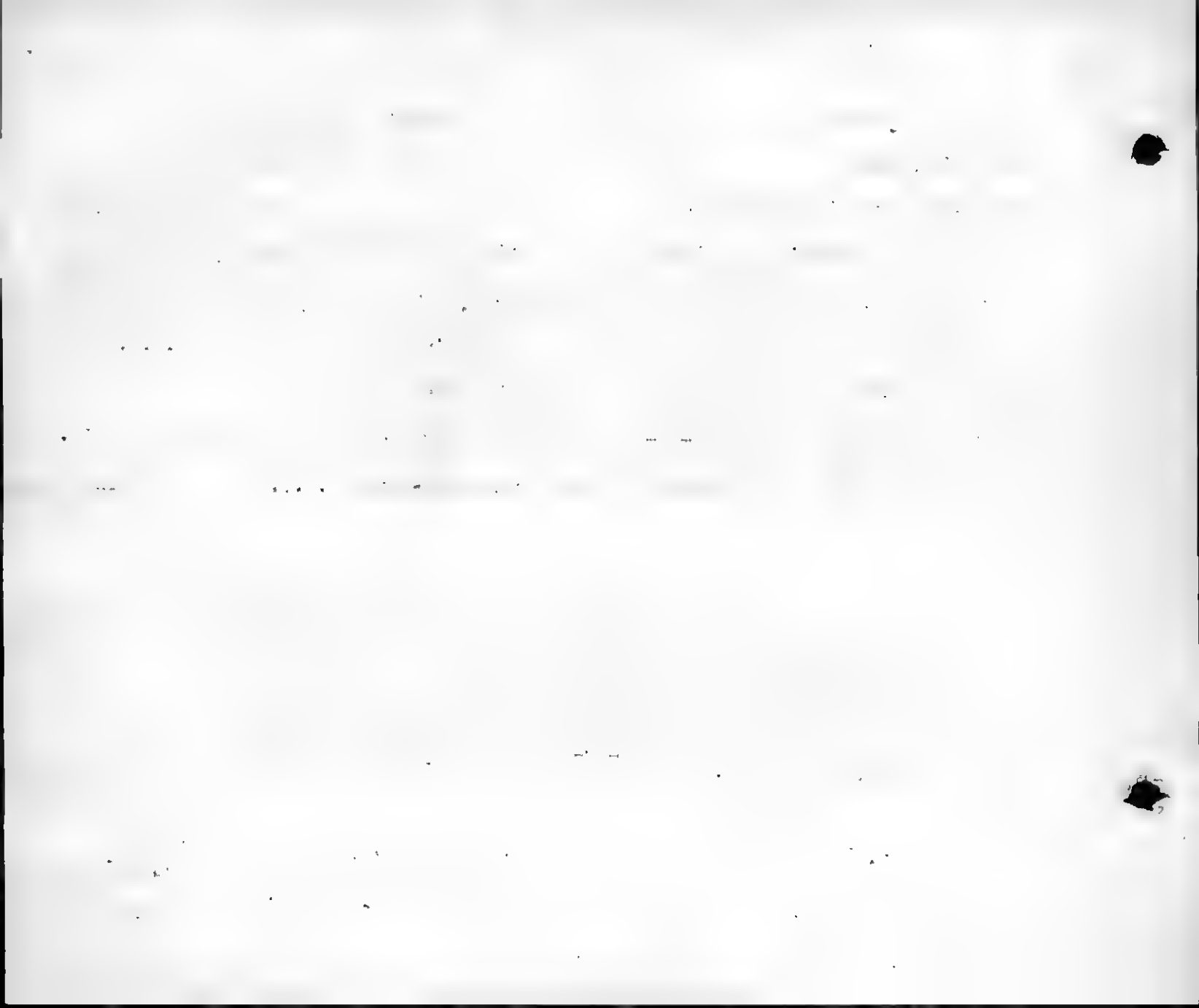
Reg. Dist. No. 4245

4252

1 PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
c. LENGTH OF STAY IN 1b <b>10 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Millington</b> d. STREET ADDRESS <b>14 X-2</b>	
3 NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Charles</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 7, 1877</b>
9. AGE (In years last birthday) <b>83</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>farm hand</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Smith</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Ericson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>215-32-2140</b>	
17. INFORMANT <b>Medical Records at Eastern Shore State Hosp.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis with C.V.D.</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>several years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-30-58</b> , 19 <b>61</b> to <b>4/10</b> , 19 <b>61</b> ; that I last saw the deceased alive on <b>April 10</b> , 19 <b>61</b> , and that death occurred at <b>1/30p</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Simon Virkutis</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. Simon Virkutis</b>	
22a. BURNAL CREMATION <b>Burnal</b>		22b. DATE THEREOF <b>April 12/1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Crumpton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crumpton Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William M. Williams</b> ADDRESS		24a. REC'D BY REGISTRAR DATE <b>APR 13 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kious</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







1.2  
FOR STATE  
HEALTH DEPT.

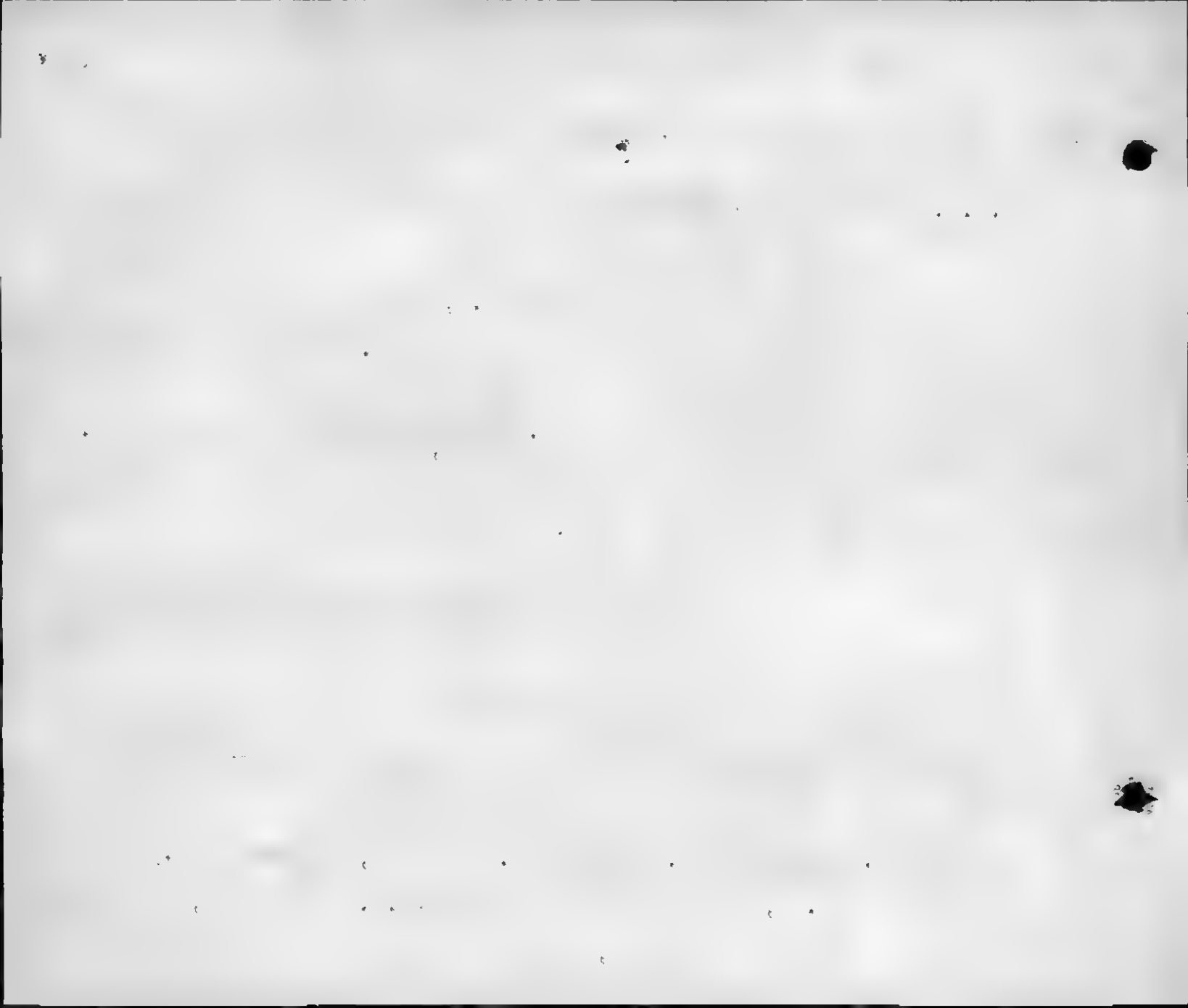
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
4254 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04247

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN b. <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>D.O.A. Cambridge Maryland Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>Sussex</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seaford</b> d. STREET ADDRESS <b>506 Pine St</b>	
3. NAME OF DECEASED (Type or print) <b>OTIS LLOYD TOWNSEND</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>25th</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 3, 1901</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Methodist Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Church</b>	
11. BIRTHPLACE (State or foreign country) <b>Wicomico Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Littleton Marion Townsend</b>		14. MOTHER'S MAIDEN NAME <b>Ida Belle Malone</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>17. INFORMANT</b> <b>Mrs. Maude Townsend (Wife)</b> Address <b>506 Pine St. Seaford, Delaware</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Instant.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. John Mace Jr. #6 Church St. Cambridge, Maryland</b>		DATE SIGNED <b>Apr. 29 / 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Apr. 29, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Shad Point Cemetery-R.D.#</b>	22d. LOCATION (City, town, or country) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY, MARYLAND</b>	
24a. REC'D BY REG. STRAR <b>MAY 3 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	





## CERTIFICATE OF DEATH

Reg. Dist. No. 04248

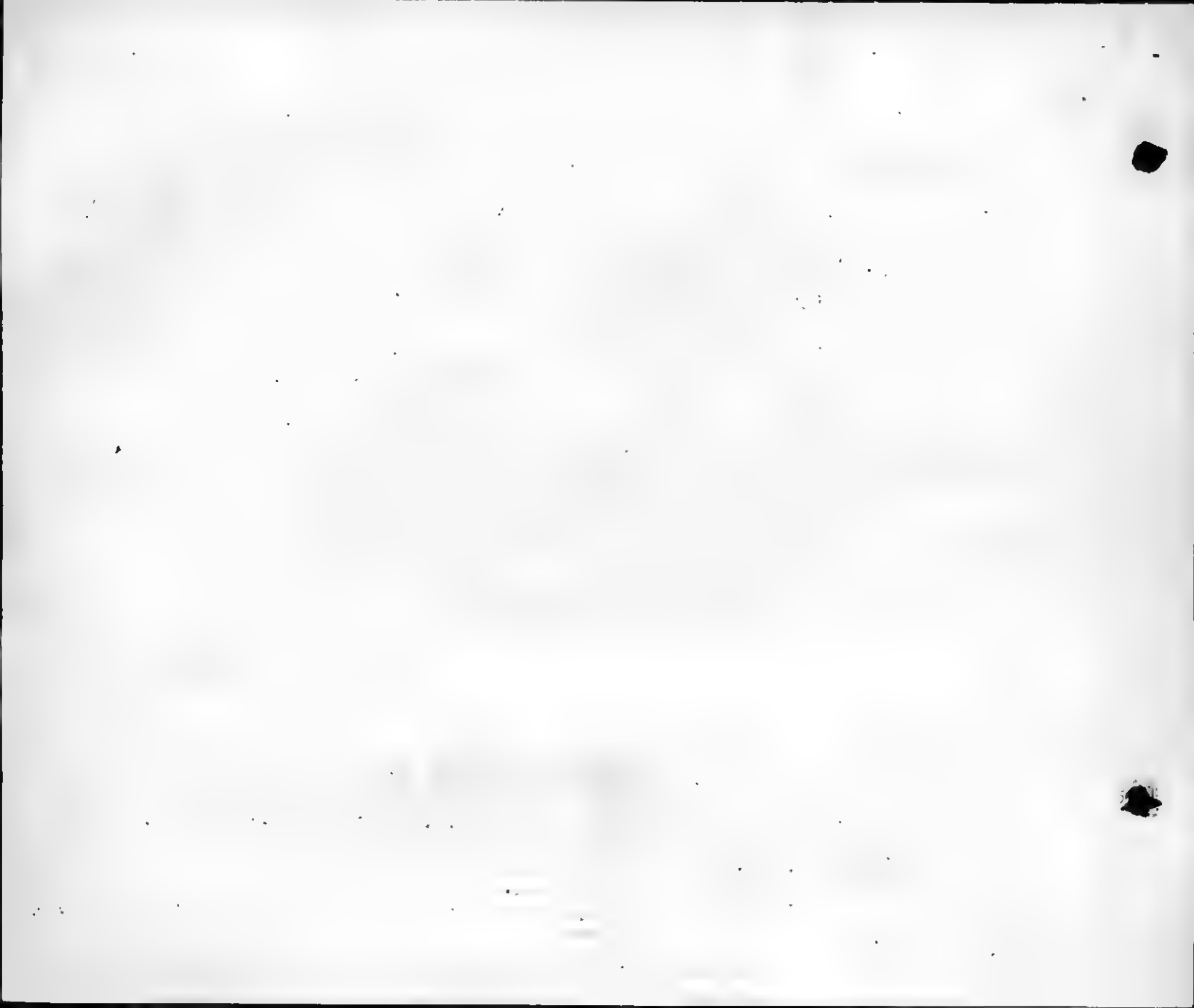
4253

1 PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b> c. LENGTH OF STAY IN 1b <b>1 mo. 14 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke city</b> d. STREET ADDRESS <b>RT. 2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Hattie</b> First <b>C.</b> Middle <b>Tull</b> Last		4. DATE OF DEATH <b>April 27 1961</b> Month Day Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-7-80</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Robert C. Colona</b>	
14. MOTHER'S MAIDEN NAME <b>Annie Payton</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		INFORMANT <b>Hospital records</b> Address <b>Cambridge Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Haemorrhage</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>unk</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>Mar 3 1961</b> to <b>April 27 1961</b> , that I last saw the deceased alive on <b>April 26 1961</b> , and that death occurred at <b>2:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>E.S.S. Hospital, Cambridge, Md.</b> DATE SIGNED <b>4-27-61</b>			
ACTUAL SIGNATURE <b>Thomas J. Dredge</b> PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>		M.D. <b>E.S.S. Hospital, Cambridge, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4-29-61</b>	22c. NAME OF CEMETERY <b>SALEM METHODIST</b>	22d. LOCATION (City, town, or county) (State) <b>POCOMOKE CITY, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert H. Watson</b> ADDRESS <b>Pocomoke City, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 1 '61</b> DATE	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 1

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

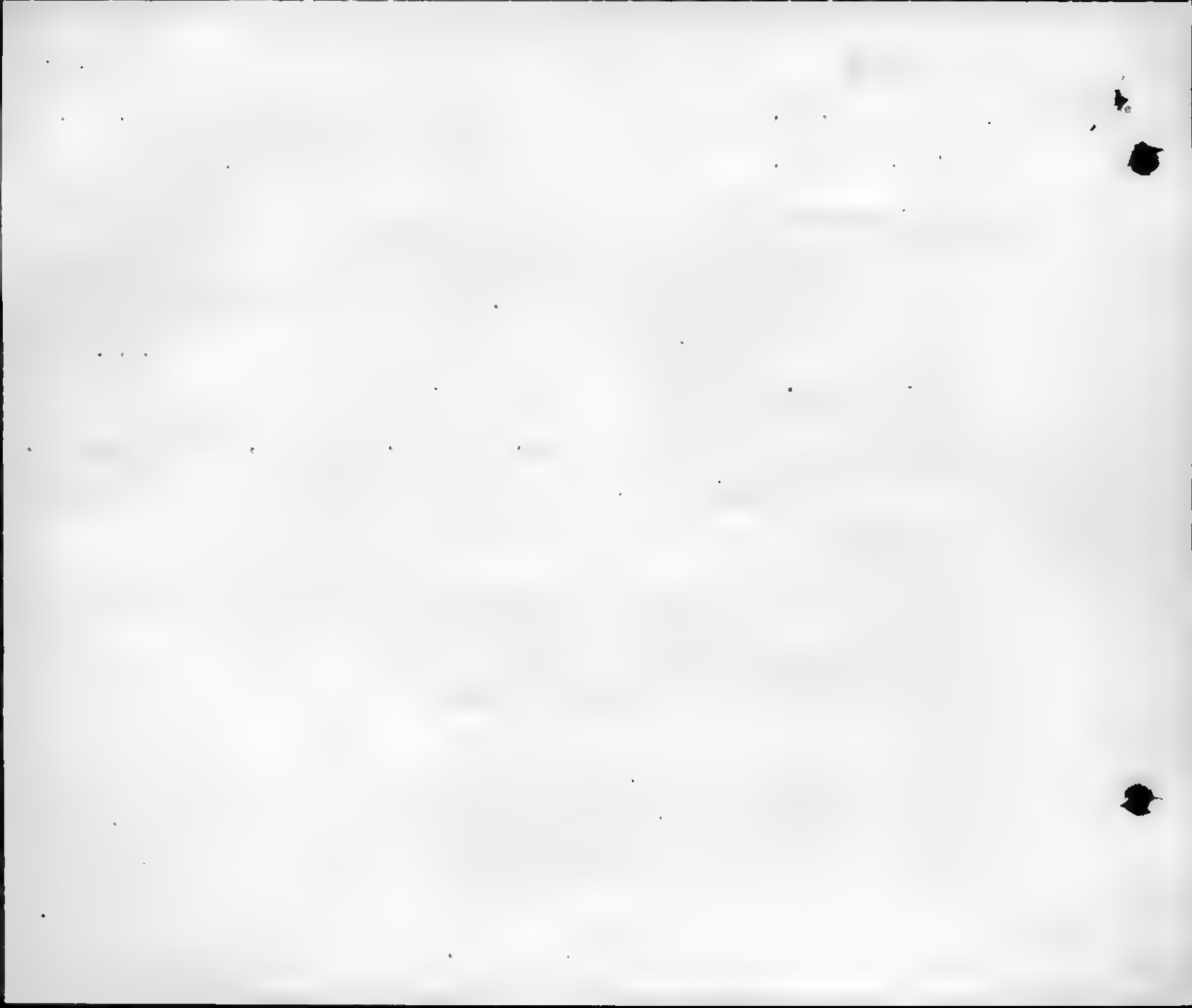
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15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1256

04249

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER, CO.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER, CO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE, MARYLAND.</b>		c. LENGTH OF STAY IN 1b <b>1 WEEK</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FISHING CREEK, MARYLAND.</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CAMBRIDGE MARYLAND HOSPITAL</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. STREET ADDRESS <b>NONE</b>	
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>VANDERLAAN</b> Last <b>VANDERLAAN</b>		4. DATE OF DEATH Month <b>4</b> Day <b>10</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 7 1873</b>
9. AGE (In years last birthday) yrs. <b>88</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
11. BIRTHPLACE (State or foreign country) <b>ROTTERDAM HOLLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PIETER VANDERLAAN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>YES</b>	
17. INFORMANT <b>MRS. JOHANNA S. VANDERLAAN, FISHING CREEK, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19 61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/28 1960</b> to <b>4/10 1961</b> , that (I) (we) last saw the deceased alive on <b>4/10 1961</b> , and that death occurred <b>4/10 1961</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>W.E. Gunby Jr.</b> M.D.		22b. DATE SIGNED <b>4/12/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>W.E. GUNBY JR</b>		22d. ADDRESS <b>Cambridge Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/12/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HOOSIER MEMORIAL CHURCH YARD</b>		23d. LOCATION (City, town, or county) (State) <b>FISHING CREEK, MARYLAND.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>LE COMPTE FUNERAL SERVICE, CAMBRIDGE, MARYLAND.</b>		25a. REC'D BY REGISTRAR <b>DATE APR 17 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04250

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>		c. LENGTH OF STAY IN 1b <b>1 year 2 mos</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastern Shore State Hospital, Cambridge, Md</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jacob Weller</b>		4. DATE OF DEATH <b>April 24 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/8/74</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Silas Weller</b>		14. MOTHER'S MAIDEN NAME <b>Sarah McClain</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Records E.S.State Hospital, Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 42001 DUE TO (b) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome, senile brain disease with psychotic reaction.</b> INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		DATE SIGNED <b>4/24/61</b>	
22a. BURIAL, CREMATION, or REINTERMENT (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/27/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sudburyville Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Sudburyville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edmond Fellows</b>		24a. REC'D BY REGISTRAR <b>APR 27 '61</b>	
ADDRESS <b>Millington, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Carroll S. Kline</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4258

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04251

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>4 Mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>E. S. State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> d. STREET ADDRESS <b>Standard Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Leila Catharine Willey</b>		4. DATE OF DEATH Month <b>4</b> Day <b>25</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-2-89</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Sterling</b>		14. MOTHER'S MAIDEN NAME <b>Mary Mister</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Records E.S.State Hosp. Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome with senile brain disease with psychotic reaction</b> INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>4-25-61</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	22b. DATE THEREOF <b>April 28, '61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sunny Ridge</b>	22d. LOCATION (City, town, or county) (State) <b>Crisfield Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Harvey Bradshaw</b>		24a. REC'D BY REGISTRAR <b>MAY 1 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26